		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0054460

Facility Name: Carrier Mills Nursing & Rehab Center

Address: 6789 Rt 45 E Box 68 (Number) Carrier Mills (City) 62917 (Zip Code)

County: Saline

Telephone Number: (618) 994-2323 **Fax #** (618) 994-4082

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2017

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (630) 361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,389	4,389	8
9	SNF/PED					9
10	ICF	18,236	5,131	3,783	27,150	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,236	5,131	8,172	31,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.28%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/17

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/17 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 4,000

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	203,494	10,688	10,087	224,269		224,269		224,269			1
2	Food Purchase		161,861		161,861		161,861		161,861			2
3	Housekeeping	169,422	12,434		181,856		181,856	1,187	183,043			3
4	Laundry	67,769	8,731		76,500		76,500		76,500			4
5	Heat and Other Utilities			96,469	96,469		96,469	405	96,874			5
6	Maintenance	47,349	12,865	16,763	76,977		76,977	791	77,768			6
7	Other (specify):* Waste Removal			15,125	15,125		15,125	105	15,230			7
8	TOTAL General Services	488,034	206,579	138,444	833,057		833,057	2,488	835,545			8
	B. Health Care and Programs											
9	Medical Director			7,250	7,250		7,250		7,250			9
10	Nursing and Medical Records	1,452,584	62,004	59,608	1,574,196		1,574,196		1,574,196			10
10a	Therapy			19,523	19,523		19,523		19,523			10a
11	Activities	46,480	3,220	4,007	53,707		53,707		53,707			11
12	Social Services	21,169		1,077	22,246		22,246		22,246			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,520,233	65,224	91,465	1,676,922		1,676,922		1,676,922			16
	C. General Administration											
17	Administrative	94,886		347,870	442,756		442,756	(314,983)	127,773			17
18	Directors Fees											18
19	Professional Services			45,721	45,721		45,721	1,707	47,428			19
20	Dues, Fees, Subscriptions & Promotions			16,813	16,813		16,813	(2,082)	14,731			20
21	Clerical & General Office Expenses	79,594	16,477	23,010	119,081		119,081	92,951	212,032			21
22	Employee Benefits & Payroll Taxes			271,869	271,869		271,869		271,869			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,399	1,399		1,399	20	1,419			24
25	Other Admin. Staff Transportation			9,721	9,721		9,721	1,141	10,862			25
26	Insurance-Prop.Liab.Malpractice			58,470	58,470		58,470	310	58,780			26
27	Other (specify):* WLC Benefits Alloc							11,148	11,148			27
28	TOTAL General Administration	174,480	16,477	774,873	965,830		965,830	(209,788)	756,042			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,182,747	288,280	1,004,782	3,475,809		3,475,809	(207,300)	3,268,509			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' PREPARATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Carrier Mills Nursing & Rehab Center #0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			112,520	112,520		112,520	(98,479)	14,041			30
31	Amortization of Pre-Op. & Org.							532	532			31
32	Interest			3,882	3,882		3,882	752	4,634			32
33	Real Estate Taxes			41,986	41,986		41,986	796	42,782			33
34	Rent-Facility & Grounds			910,298	910,298		910,298	1,440	911,738			34
35	Rent-Equipment & Vehicles			5,827	5,827		5,827		5,827			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,074,513	1,074,513		1,074,513	(94,959)	979,554			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			82	82		82		82			38
39	Ancillary Service Centers		150,119	720,499	870,618		870,618		870,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,038	218,038		218,038		218,038			42
43	Other (specify):* **Disallowed Costs**			84,503	84,503		84,503	(84,503)				43
44	**TOTAL Special Cost Centers**		150,119	1,023,122	1,173,241		1,173,241	(84,503)	1,088,738			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,182,747	438,399	3,102,417	5,723,563		5,723,563	(386,762)	5,336,801			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,184)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(104,959)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(358)	43		13
14	Non-Care Related Interest	(131)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,082)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(375)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(57,528)	43		24
25	Fund Raising, Advertising and Promotional	(18,774)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(2,756)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (194,147)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(192,615)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (192,615)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (386,762)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Carrier Mills Nursing & Rehab Center

ID# 0054460

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (284)	43	1
2	Miscellaneous income offset	(2,472)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,756)		49

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Scott Stout	100	DuQuoin Nursing and Rehab Center	DuQuoin	WLC Management Fir	Harrisburg	Management Co.
		Eldorado Rehab and Healthcare	Eldorado			
		Greenville Nursing and Rehab Center	Greenville			
		Pinckneyville Nursing and Rehab Center	Pinckneyville			
		Saline Care Nursing and Rehab Center	Harrisburg			
		Stonebridge Nursing and Rehab Center	Benton			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	WLC Management Firm, LLC	100.00%	$ 1,187	$ 1,187	1
2	V	5	Utilities		WLC Management Firm, LLC	100.00%	405	405	2
3	V	6	Maintenance		WLC Management Firm, LLC	100.00%	791	791	3
4	V	7	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	105	105	4
5	V	17	Administrative	347,870	WLC Management Firm, LLC	100.00%	32,887	(314,983)	5
6	V	19	Professional Services		WLC Management Firm, LLC	100.00%	1,707	1,707	6
7	V	21	Clerical & General Office		WLC Management Firm, LLC	100.00%	95,423	95,423	7
8	V	24	Travel & Seminar		WLC Management Firm, LLC	100.00%	20	20	8
9	V	25	Other Admin Staff Transport		WLC Management Firm, LLC	100.00%	1,141	1,141	9
10	V	26	Insurance-Prop/Liab/Malprac		WLC Management Firm, LLC	100.00%	310	310	10
11	V	27	Mgmt Allocation of Benefits		WLC Management Firm, LLC	100.00%	11,148	11,148	11
12	V	30	Depreciation		WLC Management Firm, LLC	100.00%	6,480	6,480	12
13	V	31	Amortization-Pre Org Costs		WLC Management Firm, LLC	100.00%	532	532	13
14	Total			$ 347,870			$ 152,136	$ * (195,734)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	WLC Management Firm, LLC	100.00%	$ 883	$ 883	15
16	V	33	Real Estate Taxes		WLC Management Firm, LLC	100.00%	796	796	16
17	V	34	Rent-Faclity & Grounds		WLC Management Firm, LLC	100.00%	1,440	1,440	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,119	$ * 3,119	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Scott Stout	Stockholder	Administrative	100.00	See Att Sch 7A	7.1	17.75	Alloc. Salary	$ 32,887	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 32,887		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WLC Management Firm, LLC
Street Address: 215 East Locust Street
City / State / Zip Code: Harrisburg, IL 62946
Phone Number: (618) 294-8696
Fax Number: (618) 294-8699

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Census	177,417	7	$ 6,679	$ 6,679	31,539	$ 1,187	1
2	5	Utilities	Census	177,417	7	2,280		31,539	405	2
3	6	Maintenance	Census	177,417	7	4,451		31,539	791	3
4	7	Mgmt Allocation of Benefits	Census	177,417	7	593		31,539	105	4
5	17	Administrative	Census	177,417	7	185,000	185,000	31,539	32,887	5
6	19	Professional Services	Census	177,417	7	9,603		31,539	1,707	6
7	21	Clerical & General Office	Census	177,417	7	536,784	522,122	31,539	95,423	7
8	24	Travel & Seminar	Census	177,417	7	115		31,539	20	8
9	25	Other Admin Staff Transport	Census	177,417	7	6,420		31,539	1,141	9
10	26	Insurance-Prop/Liab/Malprac	Census	177,417	7	1,744		31,539	310	10
11	27	Mgmt Allocation of Benefits	Census	177,417	7	62,710		31,539	11,148	11
12	30	Depreciation	Census	177,417	7	36,453		31,539	6,480	12
13	31	Amortization-Pre Org Costs	Census	177,417	7	2,991		31,539	532	13
14	32	Interest	Census	177,417	7	4,967		31,539	883	14
15	33	Real Estate Taxes	Census	177,417	7	4,478		31,539	796	15
16	34	Rent-Faclity & Grounds	Census	177,417	7	8,098		31,539	1,440	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 873,366	$ 713,801		$ 155,255	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Legence Bank		X	Line of Credit		10/23/17	249,131		10/30/18	0.0475	3,882	6
7												7
8												8
9	TOTAL Facility Related						$ 249,131	$			$ 3,882	9
	B. Non-Facility Related*											
10												10
11									Interest Income Offset		(131)	11
12									Allocated From WLC		883	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 752	14
15	TOTALS (line 9+line14)						$ 249,131	$			$ 4,634	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 35,165	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	$ 38,474	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,309	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,474	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Allocated from Mgmt Co**	999	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ 999	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 42,782	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013		8
2014		9
2015		10
2016	35,225	11
2017	38,474	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Note: Beginning balance adjusted to actual (corrected due from prior owner)

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carrier Mills Nursing & Rehab Center COUNTY Saline

FACILITY IDPH LICENSE NUMBER 0054460

CONTACT PERSON REGARDING THIS REPORT Scott Stout

TELEPHONE (618) 294-8696 FAX #: (618) 294-8699

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-098-03	Long Term Care Property	$ 38,474.24	$ 38,474.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,474.24	$ 38,474.24

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,462 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 7,980
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 532
4. Dates Incurred: 2017

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Water Heater			2018	7,006		20	175	175	175	9
10	3.5 Ton Rooftop AC Unit			2018	6,000		20	150	150	150	10
11	Replace Roof on New Portion of Building			2018	66,797		20	1,670	1,670	1,670	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20	Financial Statement Depreciation					112,520			(112,520)		20
21											21
22											22
23	Allocated from WLC Management			2018	55,767		25	1,116	1,116	1,116	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 135,570	$ 112,520		$ 3,111	$ (109,409)	$ 3,111	70

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 15,989	$	$ 1,599	$ 1,599	10 yrs	$ 2,398	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from WLC Mgmt	689		69	69		114	74
75	TOTALS	$ 16,678	$	$ 1,668	$ 1,668		$ 2,512	75

D. Vehicle Costs. (See instructions.)*

	bmn 1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2016 Dodge Caravan	2018	$ 31,736	$	$ 3,967	$ 3,967	4	$ 3,967	76
77										77
78	Allocated from WLC Mgmt			22,186		5,295	5,295		5,586	78
79										79
80	TOTALS			$ 53,922	$	$ 9,262	$ 9,262		$ 9,553	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 206,170	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 112,520	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 14,041	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (98,479)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,176	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CTR Partnership, LP

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1979	42	2/17/17	$ 910,298			3
4	Additions	1992	57					4
5		Allocated from WLC			1,440			5
6								6
7	TOTAL		99		$ 911,738 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning 3/1/2017
Ending 2/29/2032

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	2/28/2019	$ 912,252
13.	2/29/2020	$ 941,900
14.	2/28/2021	$ 972,512

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,827 Description: Medical Equipment $5,575: Dietary Equipment $252
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3), 39(3)	hrs	$	16,426	$ 278,398	$	16,426	$ 278,398	1
2	Licensed Speech and Language Development Therapist	10A(3), 39(3)	hrs		7,603	132,273		7,603	132,273	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 39(3)	hrs		18,460	293,920		18,460	293,920	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				150,119		150,119	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	42,489	$ 704,591	$ 150,119	42,489	$ 854,710	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 546,077	$ 546,077	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,432)	836,337	836,337	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,936	9,936	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,392,350	$ 1,392,350	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	90,352	135,570	15
16	Equipment, at Historical Cost	38,448	70,600	16
17	Accumulated Depreciation (book methods)	(127,328)	(15,176)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,472	$ 190,994	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,393,822	$ 1,583,344	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,590	$ 121,590	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,465	83,465	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,254	1,254	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,474	38,474	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	5,083	5,083	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 249,866	$ 249,866	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 249,866	$ 249,866	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,143,956	$ 1,333,478	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,393,822	$ 1,583,344	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 564,359	1
2	Restatements (describe):		2
3	**Prior Period Adjustment-Depreciation**	(14,808)	3
4	**Prior Period Adjustment-Nursing Supplies**	(182)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 549,369	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	594,587	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 594,587	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,143,956	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,025,382	1
2	Discounts and Allowances for all Levels	13,571	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,038,953	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	270,762	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 270,762	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,365	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	434	19
20	Radiology and X-Ray	800	20
21	Other Medical Services	233	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,832	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous**	2,472	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,472	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,318,150	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	833,057	31
32	Health Care	1,676,922	32
33	General Administration	965,830	33
	B. Capital Expense		
34	Ownership	1,074,513	34
	C. Ancillary Expense		
35	Special Cost Centers	955,203	35
36	Provider Participation Fee	218,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,723,563	40
41	**Income before Income Taxes (line 30 minus line 40)****	594,587	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 594,587	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,474,557	44
45	Private Pay - Net Inpatient Revenue	698,937	45
46	Medicare - Net Inpatient Revenue	2,008,022	46
47	Other-(specify) **Insurance**	167,933	47
48	Other-(specify) **VA**	689,504	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,038,953	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,964	2,092	$ 65,756	$ 31.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,584	4,857	126,652	26.08	3
4	Licensed Practical Nurses	24,253	25,245	515,530	20.42	4
5	CNAs & Orderlies	58,041	60,192	744,646	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,903	2,056	21,208	10.32	9
10	Activity Assistants	2,425	2,524	25,272	10.01	10
11	Social Service Workers	1,822	1,913	21,169	11.07	11
12	Dietician					12
13	Food Service Supervisor	2,324	2,472	30,548	12.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,076	18,734	172,946	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,524	2,703	47,349	17.52	17
18	Housekeepers	16,806	17,420	169,422	9.73	18
19	Laundry	7,601	7,755	67,769	8.74	19
20	Administrator	1,917	2,109	70,189	33.28	20
21	Assistant Administrator	1,807	1,911	24,697	12.92	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,667	7,047	79,594	11.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,714	159,030	$ 2,182,747 *	$ 13.73	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 10,087	L1, C3	35
36	Medical Director	Monthly	7,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,077	L11, C3	44
45	Social Service Consultant	16	1,077	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	232	$ 21,891		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	595	$ 31,004	L10, C3	50
51	Licensed Practical Nurses	291	10,419	L10, C3	51
52	Certified Nurse Assistants/Aides	614	15,785	L10, C3	52
53	TOTAL (lines 50 - 52)	1,500	$ 57,208		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christy L. Barter	Administrator	0	$ 70,189
Tonya Walker	Asst Admin	0	24,697
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,886

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 347,870
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 347,870

C. Professional Services

Vendor/Payee	Type	Amount
Sandberg Phoenix & Von Gontard	Legal	$ 4,300
E-Solutions, Inc.	Health Info Management	1,731
American Healthtech	LTC Software	21,929
Information Controls	Payroll Service	4,093
WH Administrators, Inc	ACA Compliance Consultant	7,730
Templin Healthcare Accounting	Accounting Services	4,438
Kemper CPA Group	Accounting Services	1,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 45,721

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,936
Unemployment Compensation Insurance	11,779
FICA Taxes	163,165
Employee Health Insurance	23,257
Employee Meals	1,063
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals/Drug Tests	4,097
Life/Disability Insurance	6,577
Other Employee Benefits	3,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 271,869

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,186
Health Care Worker Background Check (Indicate # of checks performed 41)	1,566
Patient Background Checks 129	2,080
License & Permits	
Dues & Subcriptions	2,457
IHCA	6,534
Less: Public Relations Expense	(2,082)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,731

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,147
Seminar Expense	252
Allocated From WLC Mgmt Firm	20
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,419

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Carrier Mills Nursing & Rehab Center # 0054460 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **6,534 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,320** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **Yes**
If YES, give effective date of lease. **2/17/17**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Carrier Mills Nursing & Rehab Ctr #0025130

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **218,038**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,063** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Line 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees