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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0010660

Facility Name: Carlyle Healthcare Center

Address: 501 Clinton Street (Number) Carlyle (City) 62231 (Zip Code)

County: Clinton

Telephone Number: 618-594-3112 **Fax #** 618-594-2393

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1969

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Dave Reis **Telephone Number:** 217-228-1950
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 01/01/2012 to 12/31/2012 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) (Date)
(Print Name and Title) Dave Reis, President
(Firm Name & Address) WDM Computer Services Inc., 1900 Harrison Street Quincy, IL 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

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**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3	17	Intermediate (ICF)	17	6,222	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	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			2,591	2,591	8
9	SNF/PED					9
10	ICF	18,458	13,669		32,127	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,458	13,669	2,591	34,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.03%

D. How many bed-hold days during this year were paid by the Department?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Laundry Services for Supportive Living

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]

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

I. On what date did you start providing long term care at this location?
Date started 04/01/1969

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 2,591

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 2012 Fiscal Year: _____

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	289,702	18,245	12,008	319,955		319,955		319,955			1
2	Food Purchase		249,330		249,330	(5,000)	244,330	(17,583)	226,747			2
3	Housekeeping	133,838	30,235		164,073		164,073		164,073			3
4	Laundry	95,210	18,108	1,346	114,664		114,664	(1,152)	113,512			4
5	Heat and Other Utilities			148,396	148,396		148,396		148,396			5
6	Maintenance	128,966	38,357	51,055	218,378		218,378		218,378			6
7	Other (specify):* Income Tax			17,846	17,846		17,846	(17,846)				7
8	TOTAL General Services	647,716	354,275	230,651	1,232,642	(5,000)	1,227,642	(36,581)	1,191,061			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	1,914,474	158,216	7,185	2,079,875		2,079,875	(9,860)	2,070,015			10
10a	Therapy	75,741		590,967	666,708		666,708		666,708			10a
11	Activities	126,269	14,448	2,640	143,357		143,357	(5,708)	137,649			11
12	Social Services	43,633		1,580	45,213		45,213		45,213			12
13	CNA Training											13
14	Program Transportation	442	6,823		7,265		7,265	(7,265)				14
15	Other (specify):* Sales Tax			5,498	5,498		5,498	(5,498)				15
16	TOTAL Health Care and Programs	2,160,559	179,487	613,970	2,954,016		2,954,016	(28,331)	2,925,685			16
	C. General Administration											
17	Administrative	238,881			238,881		238,881	(50,000)	188,881			17
18	Directors Fees											18
19	Professional Services			469,500	469,500	(461)	469,039	(368,104)	100,935			19
20	Dues, Fees, Subscriptions & Promotions			44,531	44,531	461	44,992	(19,466)	25,526			20
21	Clerical & General Office Expenses	144,144	29,646	21,026	194,816		194,816	(15,162)	179,654			21
22	Employee Benefits & Payroll Taxes			427,703	427,703	5,000	432,703	(1,068)	431,635			22
23	Inservice Training & Education			3,348	3,348		3,348		3,348			23
24	Travel and Seminar			22,823	22,823		22,823	589	23,412			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,011	61,011		61,011		61,011			26
27	Other (specify):* Loan Costs				7,857		7,857	(7,857)				27
28	TOTAL General Administration	383,025	29,646	1,049,942	1,470,470	5,000	1,475,470	(461,068)	1,014,402			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,191,300	563,408	1,894,563	5,657,128		5,657,128	(525,980)	5,131,148			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 Carlyle Healthcare Center #0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			173,271	173,271		173,271	(3,331)	169,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,674	30,674		30,674	(4,125)	26,549			32
33	Real Estate Taxes			60,007	60,007		60,007		60,007			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			988	988		988		988			35
36	Other (specify):* Basd Debts			36,977	36,977		36,977	(36,977)				36
37	TOTAL Ownership			301,917	301,917		301,917	(44,433)	257,484			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,083		99,083		99,083		99,083			39
40	Barber and Beauty Shops		2,794	22,815	25,609		25,609		25,609			40
41	Coffee and Gift Shops		11,215		11,214		11,214		11,214			41
42	Provider Participation Fee			222,808	222,808		222,808		222,808			42
43	Other (specify):* Penalty			1,504	1,504		1,504	(1,504)				43
44	TOTAL Special Cost Centers		113,092	247,127	360,218		360,218	(1,504)	358,714			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,191,300	676,500	2,443,607	6,319,263		6,319,263	(571,917)	5,747,346			45

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(922)	10		3
4	Non-Patient Meals	(15,854)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,255)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(8,938)	10		7
8	Laundry for Non-Patients	(1,152)	4		8
9	Non-Straightline Depreciation	(3,331)	30		9
10	Interest and Other Investment Income	(4,125)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,729)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,498)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(70,400)	19		15
16	Personal Expenses (Including Transportation)	(7,265)	14		16
17	Non-Care Related Fees	(7,200)	21		17
18	Fines and Penalties	(1,504)	43		18
19	Entertainment	(5,708)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance	(1,068)	22		21
22	Special Legal Fees & Legal Retainers	(163)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,977)	36		24
25	Fund Raising, Advertising and Promotional	(19,803)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,846)	7		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Refinance	(7,857)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (225,595)		$	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)	(346,322)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (346,322)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (571,917)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlyle Healthcare Center **#** 0010660 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17,583)	0	0	0	0	0	0	0	0	0	0	(17,583)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,152)	0	0	0	0	0	0	0	0	0	0	(1,152)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(17,846)	0	0	0	0	0	0	0	0	0	0	(17,846)	7
8	**TOTAL General Services**	(36,581)	0	0	0	0	0	0	0	0	0	0	(36,581)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,860)	0	0	0	0	0	0	0	0	0	0	(9,860)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,708)	0	0	0	0	0	0	0	0	0	0	(5,708)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(7,265)	0	0	0	0	0	0	0	0	0	0	(7,265)	14
15	Other (specify):*	(5,498)	0	0	0	0	0	0	0	0	0	0	(5,498)	15
16	**TOTAL Health Care and Programs**	(28,331)	0	0	0	0	0	0	0	0	0	0	(28,331)	16
	C. General Administration													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(70,400)	(297,704)	0	0	0	0	0	0	0	0	0	(368,104)	19
20	Fees, Subscriptions & Promotions	(19,966)	500	0	0	0	0	0	0	0	0	0	(19,466)	20
21	Clerical & General Office Expenses	(15,455)	293	0	0	0	0	0	0	0	0	0	(15,162)	21
22	Employee Benefits & Payroll Taxes	(1,068)	0	0	0	0	0	0	0	0	0	0	(1,068)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	589	0	0	0	0	0	0	0	0	0	589	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(106,889)	(346,322)	0	0	0	0	0	0	0	0	0	(453,211)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(171,801)	(346,322)	0	0	0	0	0	0	0	0	0	(518,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlyle Healthcare Center **#** 0010660 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(3,331)	0	0	0	0	0	0	0	0	0	0	(3,331)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,125)	0	0	0	0	0	0	0	0	0	0	(4,125)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(36,977)	0	0	0	0	0	0	0	0	0	0	(36,977)	36
37	**TOTAL Ownership**	(44,433)	0	0	0	0	0	0	0	0	0	0	(44,433)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,504)	0	0	0	0	0	0	0	0	0	0	(1,504)	43
44	**TOTAL Special Cost Centers**	(1,504)	0	0	0	0	0	0	0	0	0	0	(1,504)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(217,738)	(346,322)	0	0	0	0	0	0	0	0	0	(564,060)	45

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
Dorothy Messick	46	St. Vincent's Home	Quincy	WDM Health Services	Quincy	Management
Ann Reis	27	Clinton Manor	New Baden			
Sue Gray	27					

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	19	Management	$ 360,000	WDM Health Services		$ 58,870	$ (301,130)	1
2	V	19	Accounting				3,426	3,426	2
3	V	24	Seminar				589	589	3
4	V	21	Office				293	293	4
5	V	20	Fees				500	500	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V	17	Officer Salary	100,000	St. Vincent's Home		50,000	(50,000)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 460,000			$ 113,678	$ * (346,322)	14

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Dorothy Messick	President	Carlyle	46.00		10	20.00	Wages	$ 100,000	17-1	1
2	Ann Reis	Secretary	Carlyle	27.00		5	10.00				2
3	Sue Gray	Treasurer	Carlyle	27.00		5	10.00				3
4											4
5	Dorothy Messick	President	St. Vincent's			10	20.00				5
6	Ann Reis	Secretary	St. Vincent's			5	10.00				6
7	Sue Gray	Treasurer	St. Vincent's			5	10.00				7
8											8
9	Carlyle Healthcare Owns 100% of St. Vincent's Home			100.00							9
10											10
11	WDM Health Services Inc							Mgmt Fee	360,000	19-3	11
12	Ann Reis		Clinton Manor								12
13								TOTAL	$ 460,000		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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: WDM Management Services Inc.
Street Address: 1900 Harrison
City / State / Zip Code: Quincy, IL 62301
Phone Number: (217-228-1950
Fax Number: (217-222-6053

	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	19	Management	Patient Days	58,974	2	$ 100,000	$ 100,000	34,718	$ 58,870	1
2	19	Accounting	Patient Days	58,974	2	5,820		34,718	3,426	2
3	24	Seminar	Patient Days	58,974	2	1,000		34,718	589	3
4	21	Office	Patient Days	58,974	2	497		34,718	293	4
5	20	Fees	Patient Days	58,974	2	850		34,718	500	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	TOTALS					$ 108,167	$ 100,000		$ 63,678	25

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First National Bank		X	Mortgage	$13,400.00	04/10/10	$ 1,952,000	$	04/10/13	5.2500	$ 5,808	1
2	First National Bank		X	2nd Mortgage	$1,365.00	04/07/08	200,000		07/07/12	5.4000	2,668	2
3	First National Bank		X	Line of credit		01/01/12	250,000		12/31/12	5.2500	3,455	3
4	First National Bank		X	Refinanced	$15,000.00	04/16/12	3,013,000	2,976,530	04/16/17	4.8500	18,743	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$29,765.00		$ 5,415,000	$ 2,976,530			$ 30,674	9
	B. Non-Facility Related*											
10	Investment Interest										(4,125)	10
11	refinace costs										7,857	11
12	**** Interest is based on actual debt of Nursing Home , other interest is for Assisted living and Supportive Living											12
13	refinance costs										(7,857)	13
14	TOTAL Non-Facility Related						$	$			$ (4,125)	14
15	TOTALS (line 9+line14)						$ 5,415,000	$ 2,976,530			$ 26,549	15

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

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

** 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 Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,692	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.)		$ 2011 98981	2
3. Under or (over) accrual (line 2 minus line 1).		$ 57,199	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 39,862	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. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ **60007	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	94,415	8
	2008	97,995	9
	2009	100,665	10
	2010	96,876	11
	2011	98,891	12

** This represents the property tax accocated for the Nursing Home , see attached shhets for calculations and map

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0010660

CONTACT PERSON REGARDING THIS REPORT Harry Poole

TELEPHONE 617-594-3112 FAX #: 618-594-2393

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-18-353-005	Nursing Home	$ 98,891.28	$ 59,167.24
2.	08-08-18-353-004	Nursing Home	$ 839.51	$ 839.51
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 99,730.79	$ 60,006.75

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? X YES _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,374 B. General Construction Type: Exterior Brick Frame Steel, Concrete Number of Stories 2

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

Villa Catherine Asisted Living 834 square ft 12 units
Villa Catherine Supportive Living 12000 sq ft 17 units
Catherine Kasper Village 12 independent units

No expenses are in schedule V as they are in separate divisions

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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	Nursing Home	265,381	1969	$ 103,500	1
2					2
3	TOTALS	265,381		$ 103,500	3

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	34		1969	1969	$ 30,426	$	30	$	$	$ 30,426	4
5	4		1988	1988	99,400	3,332	30	3,332		79,684	5
6	1		1977	1977	21,293		30			21,293	6
7	25		1973	1973	138,148		30			138,148	7
8	3		1993	1993	399,471	13,420	30	13,420		266,389	8
	Improvement Type**										
9	42 BUILDING ADDTN			1974	183,451		30			183,451	9
10	GERIATIC CENTER			1975	15,496		30			15,496	10
11	REHAB CENTER			1978	10,750		30			10,750	11
12	SPRINKLER			1974	32,694		25			32,694	12
13	BUILDING IMPROVMT			1975	14,572		20			14,572	13
14	BUILDING IMPROVMT			1970	1,588		20			1,588	14
15	BUILDING IMPROVMT			1973	3,328		20			3,328	15
16	BUILDING IMPROVMT			1974	825		20			825	16
17	PLAN OF CORRECTN			1975	21,969		20			21,969	17
18	GUARDS			1980	1,379		8			1,379	18
19	ALARM SYSTEM			1980	1,200		8			1,200	19
20	BUILDING IMPVMT GARAGE			1984	12,050		15			12,050	20
21	LAND IMPROVMTS			1987	37,715		20			37,715	21
22	BUILDING IMPVMT			1988	30,824		20			30,824	22
23	BUILDING ADTN GLASS ENCLOSER			1986	319,491	10,721	30	10,721		278,395	23
24	ROOM REMODELING			1988	16,596	556	30	556		13,304	24
25	ROOM REMODELING			1989	1,948	66	30	66		1,556	25
26	WINDOWS			1989	3,230	109	30	109		3,550	26
27	ROOF			1989	11,294	386	30	386		8,977	27
28	SMOKE DET			1980	2,204		8			2,204	28
29	BUILDING IMPVMT			1993	4,932		10			4,932	29
30	HANDRAILS			1991	6,574		8			6,574	30
31	CUBICLE CURTAINS			1992	8,415		10			8,415	31
32	FRONT PORCH ADTN			1997	85,961	2,595	33	2,595		39,466	32
33	ELEVATOR			1997	83,288	4,190	20	4,190		62,688	33
34	LANDSCAPING/RAILING			1997	8,550	528	15	528		8,550	34
35	LAND IMPROVMTS			1993	51,227		15			51,227	35
36	ROOF REPAIR			1995	8,974		10			8,374	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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	FLOOR TILE	1995	$ 7,178	$	15	$	$	$ 7,178	37
38	FLOOR CORRECTION	1999	28,360	1,425	20	1,425		19,451	38
39	HALLWAY REMODELING	1999	10,315		15			10,315	39
40	NEW ROOF CTR/BOILER	2000	19,203	1,167	15	1,167		19,203	40
41	NEW GARAGE	2001	51,030	1,707	30	1,707		19,582	41
42	LANDSCAPING	2001	20,000	1,343	15	1,343		15,413	42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,685	15	1,685		19,343	43
44	WINDOWS	2001	82,000	4,120	20	4,120		45,953	44
45	CENTER ROOF	2003	29,822	1,498	20	1,498		14,844	45
46	DINNING ROOM WINDOWS	2003	41,266	2,072	20	2,072		19,507	46
47	NEW PATIO	2003	73,579	3,696	20	3,696		36,309	47
48	SPRINKLER WALKINCOOLER/PATIO	2003	7,524	376	20	376		3,730	48
49	LOADING DOCK LIFT	2003	16,905	1,134	15	1,134		11,141	49
50	HOT WATER HTR	2004	3,285	376	8	376		3,285	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	353	15	353		2,887	51
52	TUCKPOINTING	2004	6,835	684	10	684		5,696	52
53	TRANSFORMER FOR BUILDING	2004	15,008	756	20	756		6,249	53
54	SPRINKLER MIDDLE SECTION	2004	63,606	3,181	20	3,181		25,699	54
55	SOUTH CENTER SECTION ROOF	2005	13,800	920	15	920		7,053	55
56	KITCHEN HOOD/EXHAUST SYSTEM	2005	21,763	1,088	20	1,088		8,343	56
57	FIRE SURPRESSION SYSTEM/HOOD	2005	3,114	208	15	208		1,592	57
58	DOUBLE DOORS TO ALHZIEMERS WING	2005	2,103	266	8	266		1,992	58
59	HOSPITSLITY CENTER	2005	2,922	365	8	365		2,708	59
60	KITCHEN REMODELING	2005	57,120	2,856	20	2,856		20,468	60
61	17 TREES	2005	7,613	380	20	380		2,696	61
62	DISHERWASHER ROOM REMODELING	2006	4,561	212	20	212		1,746	62
63	FIRST FLOOR DINNING ROOM REMODEL	2006	9,488	633	15	633		4,217	63
64	WONDER GUARD	2006	27,397	3,461	15	3,461		22,495	64
65	3 CENTRAL HTG/AC UNITS	2006	26,026	1,735	15	1,735		10,844	65
66	WATER SOFTNER	2006	2,995	374	8	374		2,340	66
67	NEW ROOF FIRST FL&CHAPEL	2007	9,859	493	20	493		2,793	67
68	2ND FLOOR KITCHEN	2007	5,377	269	20	269		1,501	68
69	HANDRAILS	2007	8,072	538	15	538		2,780	69
70	TOTAL (lines 4 thru 69)		$ 2,377,791	$ 75,274		$ 75,274	$	$ 1,781,346	70

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
1	Totals from Page 12A, Carried Forward		$ 2,377,791	$ 75,274		$ 75,274	$	$ 1,781,346	1
2	LANDSCAPING	2008	8,558	428	20	428		1,961	2
3	SPRINKLER	1997	34,279	1,741	15	1,741		34,279	3
4	Front Sign	2009	17,926	1,195	15	1,195		4,780	4
5	Elevator improvmts	2009	8,679	579	15	579		2,267	5
6	South wing SPA	2009	31,048	1,035	30	1,035		3,795	6
7	Front Lot Lidgts	2009	35,929	2,395	15	2,395		8,783	7
8	South Wing Roof	2009	38,900	1,970	20	1,970		6,237	8
9	2nd Floor Spa	2010	15,874	529	30	529		1,191	9
10	Front Landscaping	2010	19,768	1,317	15	1,317		3,404	10
11	Kitchen A/C	2010	6,753	450	15	450		1,163	11
12	Elevator to code	2012	157,456	4,305	30	4,305		4,305	12
13	2nd Floor Dinnng Room A/C	2012	4,443	370	8	370		370	13
14	Hazard Waste Garage	2012	1,599	116	8	116		116	14
15	RF wonder guard/door locking	2012	261,745	5,816	15	5,816		5,816	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	TOTAL (lines 1 thru 33)		$ 3,020,748	$ 97,520		$ 97,520	$	$ 1,859,813	34

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 610,305	$ 66,436	$ 66,436	$	8	$ 343,448	71
72	Current Year Purchases	25,174	1,389	1,389		8	1,389	72
73	Fully Depreciated Assets	67,880					67,880	73
74								74
75	TOTALS	$ 703,359	$ 67,825	$ 67,825	$		$ 412,717	75

D. Vehicle Costs. (See instructions.)*

	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	Resident Transportation	2012 Dodge Van	2012	$ 27,569	$ 4,595	$ 4,595	$	5	$ 4,595	76
77										77
78										78
79										79
80	TOTALS			$ 27,569	$ 4,595	$ 4,595	$		$ 4,595	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)	$ 3,855,176	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 169,940	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 169,940	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,277,125	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	Chapel renovation	$ 63,978	$ 3,331	$ 12,957	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 63,978	$ 3,331	$ 12,957	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.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ Description:
    (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.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	10a3	hrs	$		$ 231,630	$		$ 231,630	1
2	Licensed Speech and Language Development Therapist	10a3	hrs			75,365			75,365	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a3	hrs			283,972			283,972	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				99,083		99,083	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			$		$ 590,967	$ 99,083		$ 690,050	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.

STATE OF ILLINOIS

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (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	$	$ (3,137)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,451,991	3
4	Supply Inventory (priced at)		14,942	4
5	Short-Term Investments		552,758	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		52,836	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 2,069,390	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		(58,006)	12
13	Land		128,950	13
14	Buildings, at Historical Cost		4,965,830	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,473,899	16
17	Accumulated Depreciation (book methods)		(3,410,943)	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): CIP		807,356	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 3,907,086	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 5,976,476	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 274,103	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		210,549	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		41,234	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		(17,000)	35
	Other Current Liabilities(specify):			
36	deferred income		25,212	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 534,098	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,976,530	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)**	$	$ 2,976,530	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 3,510,628	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 2,465,848	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 5,976,476	48

*(See instructions.)

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,645,305	1
2	Restatements (describe):		2
3	**Prior year adjustments**	(21,017)	3
4	**2011 Income tax**	(27,410)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,596,878	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(171,755)	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) **Other Divisions**	50,025	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (121,730)	17
	B. Transfers (Itemize):		
18	**Intercompany**	(9,300)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (9,300)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,465,848	24 *

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 5,458,088	1
2	Discounts and Allowances for all Levels	84,478	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,542,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	454,757	6
7	Oxygen	5,887	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 460,644	8
	C. Other Operating Revenue		
9	Payments for Education	922	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,828	12
13	Barber and Beauty Care	24,563	13
14	Non-Patient Meals	15,854	14
15	Telephone, Television and Radio	8,255	15
16	Rental of Facility Space		16
17	Sale of Drugs	38,145	17
18	Sale of Supplies to Non-Patients	8,938	18
19	Laboratory	7,980	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,152	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 112,637	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,125	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Administration Income	7,200	28
28a	See Attaqched list	20,336	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,536	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,147,508	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,232,642	31
32	Health Care	2,954,016	32
33	General Administration	1,470,470	33
	B. Capital Expense		
34	Ownership	301,917	34
	C. Ancillary Expense		
35	Special Cost Centers	137,410	35
36	Provider Participation Fee	222,808	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,319,263	40
41	**Income before Income Taxes (line 30 minus line 40)****	(171,755)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (171,755)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,145,350	44
45	Private Pay - Net Inpatient Revenue	2,077,954	45
46	Medicare - Net Inpatient Revenue	1,319,262	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,542,566	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,980	2,064	$ 61,362	$ 29.73	1
2	Assistant Director of Nursing	1,902	2,046	54,879	26.82	2
3	Registered Nurses	16,516	17,787	387,962	21.81	3
4	Licensed Practical Nurses	29,390	31,601	592,582	18.75	4
5	CNAs & Orderlies	73,795	78,512	817,690	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,308	5,593	75,741	13.54	8
9	Activity Director	2,405	2,525	32,238	12.77	9
10	Activity Assistants	7,576	7,933	79,619	10.04	10
11	Social Service Workers	3,150	3,543	43,633	12.32	11
12	Dietician	2,000	2,184	30,325	13.89	12
13	Food Service Supervisor	2,034	2,241	28,971	12.93	13
14	Head Cook	7,874	8,637	79,052	9.15	14
15	Cook Helpers/Assistants	7,759	8,271	75,333	9.11	15
16	Dishwashers	8,703	9,061	76,021	8.39	16
17	Maintenance Workers	8,473	9,000	128,966	14.33	17
18	Housekeepers	13,659	14,526	133,838	9.21	18
19	Laundry	9,480	10,154	95,210	9.38	19
20	Administrator	2,224	2,264	96,069	42.43	20
21	Assistant Administrator	1,890	1,914	38,768	20.25	21
22	Other Administrative	3,905	4,037	72,002	17.84	22
23	Office Manager	4,176	4,176	142,812	34.20	23
24	Clerical	2,685	2,829	33,373	11.80	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 C‹ trans	46	46	442	9.61	32
33	Other(specify) Religious	1,170	1,190	14,412	12.11	33
34	TOTAL (lines 1 - 33)	218,100	232,134	$ 3,191,300 *	$ 13.75	34

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

** See instructions.

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	246	$ 12,008	1-3	35
36	Medical Director		6,100	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	6,722	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	2,640	11-3	44
45	Social Service Consultant	20	1,580	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	493	$ 29,050		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Verna Germanceri	ADM	0	$ 25,498
Joann Brave	ADM	0	35,091
Harry Poole	ADM	0	35,792
Chris Reis	Operations	0	42,500
Dorothy Messick	Officer	46	100,000
se pg 6			(50,000)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 188,881

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Herman Bodewes	Legal	$ 4,921
Sigacare	EMR	30,895
WDM Computer	Accounting/support	70,400
Onshift	Scheduling	2,823
WDM Health Servics Inc	Management	360,000
see pg 6		(297,704)
Non Allow		(70,400)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 100,935

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,922
Unemployment Compensation Insurance	26,582
FICA Taxes	236,935
Employee Health Insurance	84,341
Employee Meals	5,240
Illinois Municipal Retirement Fund (IMRF)*	
employee physicals	10,115
Officer Insurance	1,068
401k plan expenses	3,500
Non Allow	(1,068)
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,635

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	12,731
Health Care Worker Background Check	2,002
(Indicate # of checks performed 43)	
Patient Background Checks 62	
Corp Fees	976
see pg 6	500
subscriptions	1,315
Advertising	19,803
IHCA	6,175
Less: Public Relations Expense	( )
Non-allowable advertising	(19,803)
Yellow page advertising	(163)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,526

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
see attached	22,823
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,823

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. **IHCA 6175**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes 163**

(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?

(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? **8yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,654** Line **10-2**

(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? **No**
If YES, give effective date of lease.

(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 NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **222,808**
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? **N** If YES, attach an explanation of the allocation.

(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. $ **5,000** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **17,583**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **No**
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? **Yes**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **N**
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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.