

		FOR BHF USE					

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**2015  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2015)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0010660</u></p> <p><b>Facility Name:</b> <u>Carlyle Healthcare Center</u></p> <p><b>Address:</b> <u>501 Clinton Street</u> <u>Carlyle</u> <u>62231</u> Number City Zip Code</p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> <u>618-594-3112</u> <b>Fax #</b> <u>618-594-2393</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/01/1969</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b> Name: <u>Dave Reis</u> Telephone Number: <u>217-228-1950</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2015</u> to <u>12/31/2015</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 150px;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="6">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>David Reis</u> <u>President</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy, IL</u></td> </tr> <tr> <td>(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u></td> </tr> <tr> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>David Reis</u> <u>President</u>	(Firm Name & Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy, IL</u>	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	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
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Facility Name & ID Number Carlyle Healthcare Center

# 0010660 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	17	Intermediate (ICF)	17	6,205	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,869	12,088	4,374	32,331	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,869	12,088	4,374	32,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.26%

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 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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  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

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 92 and days of care provided 4,374

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 2015 Fiscal Year: \_\_\_\_\_

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

Facility Name &amp; ID Number

Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	290,203	19,035	14,569	323,807		323,807	323,807			1
2	Food Purchase		273,055		273,055	(672)	272,383	(13,683)	258,700		2
3	Housekeeping	127,086	25,034		152,120		152,120	152,120			3
4	Laundry	75,410	18,551	1,695	95,656		95,656	(1,080)	94,576		4
5	Heat and Other Utilities			164,474	164,474		164,474	164,474			5
6	Maintenance	111,030	45,708	54,608	211,346		211,346	211,346			6
7	Other (specify):* <b>Income Taxes</b>			7,087	7,087		7,087	(7,087)			7
8	<b>TOTAL General Services</b>	603,729	381,383	242,433	1,227,545	(672)	1,226,873	(21,850)	1,205,023		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000	6,000			9
10	Nursing and Medical Records	2,335,087	155,107	35,492	2,525,686		2,525,686	(1,171)	2,524,515		10
10a	Therapy	55,000		724,192	779,192		779,192	779,192			10a
11	Activities	85,404	8,673	20,284	114,361		114,361	114,361			11
12	Social Services	49,764		1,669	51,433		51,433	51,433			12
13	CNA Training										13
14	Program Transportation		5,012		5,012		5,012	(5,012)			14
15	Other (specify):* <b>sales tax</b>			3,607	3,607		3,607	(3,607)			15
16	<b>TOTAL Health Care and Programs</b>	2,525,255	168,792	791,244	3,485,291		3,485,291	(9,790)	3,475,501		16
	<b>C. General Administration</b>										
17	Administrative	199,479			199,479		199,479	199,479			17
18	Directors Fees										18
19	Professional Services			367,160	367,160		367,160	(260,188)	106,972		19
20	Dues, Fees, Subscriptions & Promotions			131,462	131,462		131,462	(66,730)	64,732		20
21	Clerical & General Office Expenses	205,523	36,096	25,418	267,037		267,037	(4,786)	262,251		21
22	Employee Benefits & Payroll Taxes			594,839	594,839	672	595,511	(5,483)	590,028		22
23	Inservice Training & Education			6,354	6,354		6,354	6,354			23
24	Travel and Seminar			21,175	21,175		21,175	21,175			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,855	75,855		75,855	75,855			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	405,002	36,096	1,222,263	1,663,361	672	1,664,033	(337,187)	1,326,846		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,533,986	586,271	2,255,940	6,376,197		6,376,197	(368,827)	6,007,370		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: 01/01/2015 Ending: 12/31/2015

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			207,992	207,992		207,992	(2,377)	205,615			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,335	73,335		73,335	(14,180)	59,155			32
33	Real Estate Taxes			56,840	56,840		56,840		56,840			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,294	1,294		1,294		1,294			35
36	Other (specify):* <b>Bad Debts</b>			59,935	59,935		59,935	(59,935)				36
37	<b>TOTAL Ownership</b>			399,396	399,396		399,396	(76,492)	322,904			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			212,982	212,982		212,982		212,982			39
40	Barber and Beauty Shops		117	18,732	18,849		18,849		18,849			40
41	Coffee and Gift Shops		84		84		84		84			41
42	Provider Participation Fee			234,516	234,516		234,516		234,516			42
43	Other (specify):* <b>Penalty</b>			4,138	4,138		4,138	(4,138)				43
44	<b>TOTAL Special Cost Centers</b>		201	470,368	470,569		470,569	(4,138)	466,431			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,533,986	586,472	3,125,704	7,246,162		7,246,162	(449,457)	6,796,705			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: 01/01/2015

Ending: 12/31/2015

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,011)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,818)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(1,171)	10		7
8	Laundry for Non-Patients	(1,080)	4		8
9	Non-Straightline Depreciation	(3,623)	30		9
10	Interest and Other Investment Income	(14,180)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,672)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,607)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(90,474)	19		15
16	Personal Expenses (Including Transportation)	(5,012)	14		16
17	Non-Care Related Fees	(641)	20		17
18	Fines and Penalties	(4,138)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(5,483)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,935)	36		24
25	Fund Raising, Advertising and Promotional	(67,566)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,087)	7		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (282,498)		\$	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	2	
		Amount	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)	(165,693)		34
35	Other- Attach Schedule	(1,266)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (166,959)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (449,457)		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Capital Improvements adjustments	\$ (1,266)	30	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
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32				32

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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	<b>Total</b>		(1,266)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlyle Healthcare Center# 0010660

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,683)	0	0	0	0	0	0	0	0	0	0	(13,683)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,080)	0	0	0	0	0	0	0	0	0	0	(1,080)	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):*	(7,087)	0	0	0	0	0	0	0	0	0	0	(7,087)	7
8	<b>TOTAL General Services</b>	<b>(21,850)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(21,850)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,171)	0	0	0	0	0	0	0	0	0	0	(1,171)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,012)	0	0	0	0	0	0	0	0	0	0	(5,012)	14
15	Other (specify):*	(3,607)	0	0	0	0	0	0	0	0	0	0	(3,607)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(9,790)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,790)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(90,474)	(169,714)	0	0	0	0	0	0	0	0	0	(260,188)	19
20	Fees, Subscriptions & Promotions	(68,207)	1,477	0	0	0	0	0	0	0	0	0	(66,730)	20
21	Clerical & General Office Expenses	(4,818)	32	0	0	0	0	0	0	0	0	0	(4,786)	21
22	Employee Benefits & Payroll Taxes	(5,483)	0	0	0	0	0	0	0	0	0	0	(5,483)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(168,982)</b>	<b>(168,205)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(337,187)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(200,622)</b>	<b>(168,205)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(368,827)</b>	<b>29</b>



## STATE OF ILLINOIS

Facility Name & ID Number Carlyle Healthcare Center# 0010660

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(4,889)	2,512	0	0	0	0	0	0	0	0	0	(2,377)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,180)	0	0	0	0	0	0	0	0	0	0	(14,180)	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):*	(59,935)	0	0	0	0	0	0	0	0	0	0	(59,935)	36
37	<b>TOTAL Ownership</b>	<b>(79,004)</b>	<b>2,512</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(76,492)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(4,138)	0	0	0	0	0	0	0	0	0	0	(4,138)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(4,138)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,138)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(283,764)	(165,693)	0	0	0	0	0	0	0	0	0	(449,457)	45

**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
Ann Reis	50	St Vincents Home Inc	Quincy			
Sue Gray	50	Clinton manor	New Baden	WDM Health SCVS	Quincy	Management

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management	\$ 214,300	WDM Health Services Inc.	0.00%	\$ 41,758	\$ (172,542)	1
2	V	19 Accounting				2,359	2,359	2
3	V	19 Legal				469	469	3
4	V	20 Subscriptions				1,477	1,477	4
5	V	30 Depreciation				2,512	2,512	5
6	V	21 Office				32	32	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 214,300			\$ 48,607	\$ * (165,693)	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:

01/01/2015

Ending:

12/31/2015

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: 01/01/2015 Ending: 12/31/2015

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Ann Reis	Secretary	Carlyle	50.00		10	20.00		\$	1
2	Sue Gray	Treasurer	Carlyle	50.00		10	20.00			2
3	Dave Reis	President	Carlyle			10	20.00			3
4	Ann Reis	Secretary	St. Vincents			10	20.00			4
5	Sue Gray	Treasurer	St. Vincents			10	20.00			5
6	Dave Reis	President	St. Vincents			10	20.00			6
7	Carlyle healthcrae owns 100 % of the St. Vincents Stock			100.00						7
8	WDM Health Services Inc.							Mgmt Fee	214,300	19-3
9	Janeane Reis	HR director	Carlyle/St Vincents		48,000			Wages	52,000	22-1
10	Ann Reis		Clinton Manor			2	4.00			10
11	Chris Reis	VP operations	Carlyle/St Vincents		30,250			Wages	105,700	17-1
12										12
13								TOTAL	\$ 372,000	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: 01/01/2015

Ending: 2/31/2015

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  NO

Name of Related Organization WDM Health Services Inc.  
 Street Address 1900 Harrison St.  
 City / State / Zip Code Quincy, IL 62301  
 Phone Number (217-228-1950)  
 Fax Number (217-222-6053)

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	19	Management	Patient Days	57,914	2	\$ 74,750	\$ 74,750	32,331	\$ 41,730	1
2	19	Outside Services	Patient Days	57,914	2	50	32,331	28		2
3	19	Legal fees	Patient Days	57,914	2	840	32,331	469		3
4	21	Postage	Patient Days	57,914	2	57	32,331	32		4
5	30	Depreciation	Patient Days	57,914	2	4,500	32,331	2,512		5
6	19	Accounting	Patient Days	57,914	2	4,225	32,331	2,359		6
7	20	Subscriptions	Patient Days	57,914	2	2,645	32,331	1,477		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					\$ 87,067	\$ 74,750		\$ 48,607	25

Facility Name & ID Number

Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	First National Bank		X	Mortgage	\$15,000.00	04/16/12	\$ 3,013,000	\$ 2,715,771	04/16/17	4.8500	\$ **44372	1						
2			X	2nd Mortgage	\$3,300.00	12/18/14	500,000	467,036	12/18/18	4.8500	23,089	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	First national Bank		X	Line of Credit			200,000	200,000	03/20/16	4.5000	5,874	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$18,300.00		\$ 3,713,000	\$ 3,382,807			\$ 73,335	9						
<b>B. Non-Facility Related*</b>																		
10	Interest Income										(14,180)	10						
11												11						
12	** Interest expense is based on actual cost of nursing home debt. Other interest is allocated for Assisted Living and Supportive Living.											12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(14,180)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,713,000	\$ 3,382,807			\$ 59,155	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>													
1. Real Estate Tax accrual used on 2014 report.		\$	<b>42,214</b>		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.)		\$	<b>2014 113396</b>		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>57,552</b>		3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>40,804</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>**56840</b>		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<b>96,876</b>	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$
<b>FOR BHF USE ONLY</b>															
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2014 \$														
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$														
<b>15</b>	LESS REFUND FROM LINE 6 \$														
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	<b>98,891</b>	9												
	2012	<b>95,278</b>	10												
	2013	<b>113,701</b>	11												
	2014	<b>113,396</b>	12												
<b>** Property tax based on allocated costs for the Nursing Home portion, see attached sheets for calculator</b>				<b>15</b>											
				<b>16</b>											

**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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton  
 FACILITY IDPH LICENSE NUMBER 0010660  
 CONTACT PERSON REGARDING THIS REPORT Gina Higgins  
 TELEPHONE 618-594-3112 FAX #: 618-594-2393

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-08-18-353-005</u>	<u>Nursing Home</u>	\$ <u>112,518.10</u>	\$ <u>55,959.66</u>
2. <u>08-08-18-353-004</u>	<u>Nursing Home</u>	\$ <u>878.03</u>	\$ <u>878.03</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>113,396.13</u></u>	\$ <u><u>56,837.69</u></u>

**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                 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.**

**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?  (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?  (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 Assisted Living 18 rooms, 15737 square feet

Villa Catherine Supportive Living 17 rooms, 12000 square feet

Catherine Kasper Village 12 independent cottages 15000 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>265,381</u>	<u>1969</u>	<u>\$ 103,500</u>	1
2					2
3	<b>TOTALS</b>	<b>265,381</b>		<b>\$ 103,500</b>	3

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	34		1969	1969	\$ 30,426	\$	30	\$		\$ 30,426	4
5	4		1988	1988	99,400	3,332	30	3,332		89,681	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		306,649	8
	<b>Improvement Type**</b>										
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		310,557	23
24		ROOM REMODELING		1988	16,596	556	30	556		14,973	24
25		ROOM REMODELING		1989	1,948	65	30	65		1,752	25
26		WINDOWS		1989	3,230	109	30	109		2,877	26
27		ROOF		1989	11,294	386	30	386		10,136	27
28		SMOKE DET		1980	2,204		8			11,294	28
29		BUILDING IMPVMT		1993	4,932		10			2,204	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		47,251	32
33		ELEVATOR		1997	83,288	4,190	20	4,190		75,258	33
34		LANDSCAPING/RAILING		1997	8,550		15			8,550	34
35		LAND IMPROVMTS		1993	51,227		15			51,227	35
36		ROOF REPAIR		1995	8,974		10			8,974	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 &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FLOOR TILE	1995	\$ 7,178	\$	15	\$	\$	\$ 7,178	37
38	FLOOR CORRECTION	1999	28,360	1,425	20	1,425		23,727	38
39	HALLWAY REMODELING	1999	10,315		15			10,315	39
40	NEW ROOF CTR/BOILER	2000	19,203		15			19,203	40
41	NEW GARAGE	2001	51,030	1,707	30	1,707		24,705	41
42	LANDSCAPING	2001	20,000	1,343	15	1,343		19,441	42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,685	15	1,685		24,398	43
44	WINDOWS	2001	82,000	4,120	20	4,120		58,312	44
45	CENTER ROOF	2003	29,822	1,498	20	1,498		19,338	45
46	DINNING ROOM WINDOWS	2003	41,266	2,072	20	2,072		25,724	46
47	NEW PATIO	2003	73,579	3,696	20	3,696		47,398	47
48	SPRINKLER WALKINCOOLER/PATIO	2003	7,524	376	20	376		4,859	48
49	LOADING DOCK LIFT	2003	16,905	1,134	15	1,134		14,543	49
50	HOT WATER HTR	2004	3,285		8			3,285	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	353	15	353		3,947	51
52	TUCKPOINTING	2004	6,835		10			6,835	52
53	TRANSFORMER FOR BUILDING	2004	15,008	756	20	756		8,517	53
54	SPRINKLER MIDDLE SECTION	2004	63,606	3,181	20	3,181		35,242	54
55	SOUTH CENTER SECTION ROOF	2005	13,800	920	15	920		9,813	55
56	KITCHEN HOOD/EXHAUST SYSTEM	2005	21,763	1,088	20	1,088		11,607	56
57	FIRE SURPRESSION SYSTEM/HOOD	2005	3,114	208	15	208		2,214	57
58	DOUBLE DOORS TO ALHZIEMERS WING	2005	2,103		8			2,103	58
59	HOSPITALITY CENTER	2005	2,922		8			2,922	59
60	KITCHEN REMODELING	2005	47,007	2,856	20	2,342	(514)	28,522	60
61	17 TREES	2005	7,613	380	20	380		3,838	61
62	DISHERWASHER ROOM REMODELING	2006	4,561	212	20	212		2,383	62
63	FIRST FLOOR DINNING ROOM REMODEL	2006	9,488	633	15	633		6,114	63
64	WONDER GUARD	2006	26,316		15			26,316	64
65	3 CENTRAL HTG/AC UNITS	2006	26,026	1,735	15	1,735		16,049	65
66	WATER SOFTNER	2006	2,995		8			2,995	66
67	NEW ROOF FIRST FL&CHAPEL	2007	9,859	493	20	493		4,272	67
68	2ND FLOOR KITCHEN	2007	5,377	269	20	269		2,807	68
69	HANDRAILS	2007	8,072	538	15	538		4,395	69
70	TOTAL (lines 4 thru 69)		\$ 2,366,597	\$ 68,052		\$ 67,538	\$ (514)	\$ 1,997,397	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,366,597	\$ 68,052		\$ 67,538	\$ (514)	\$ 1,997,397	1
2	LANDSCAPING	2008	8,558	428	20	428		3,245	2
3									3
4	Front Sign	2009	17,926	1,195	15	1,195		8,366	4
5	Elevator improvmts	2009	8,679	579	15	579		4,002	5
6	South wing SPA	2009	27,148	1,035	30	900	(135)	6,765	6
7	Front Lot Lidgts	2009	35,929	2,395	15	2,395		15,969	7
8	South Wing Roof	2009	38,900	1,970	20	1,970		12,146	8
9	2nd Floor Spa	2010	15,874	529	30	529		2,778	9
10	Front Landscaping	2010	19,768	1,318	15	1,318		7,358	10
11	Kitchen A/C	2010	6,753	450	15	450		2,514	11
12	Elevator to code	2012	157,456	5,251	30	5,251		20,057	12
13	2nd Floor Dinnng Room A/C	2012	4,443	555	8	555		2,036	13
14	Hazard Waste Garage	2012	1,599	200	8	200		716	14
15	RF wonder guard/door locking	2012	260,968	17,449	15	17,275	(174)	57,991	15
16	Stairwell Plastering	2013	10,780	552	20	552		1,207	16
17	2nd floor ceiling /plastering	2013	102,640	5,362	20	5,094	(268)	69,455	17
18	Middle section new steel roof	2013	133,290	6,732	20	6,665	(67)	13,397	18
19	West wing flooringand ceiling tile	2013	51,783	2,710	20	2,602	(108)	5,538	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)		\$ 3,269,091	\$ 116,762		\$ 115,496	\$ (1,266)	\$ 2,230,937	34

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

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	\$ 655,435	\$ 74,933	\$ 74,933	\$	8	\$ 332,613	71
72	Current Year Purchases	94,211	7,160	7,160		8	7,160	72
73	Fully Depreciated Assets	114,354				8	114,354	73
74								74
75	TOTALS	\$ 864,000	\$ 82,093	\$ 82,093	\$		\$ 454,127	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	2013 Dodge Van	2012	\$ 27,568	\$ 5,514	\$ 5,514	\$	5	\$ 21,136	76
77										77
78										78
79										79
80	TOTALS			\$ 27,568	\$ 5,514	\$ 5,514	\$		\$ 21,136	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)	\$ 4,264,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,369	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,103	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,266)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,706,200	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 Improvements	\$ 73,331	\$ 3,623	\$ 23,241	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 73,331	\$ 3,623	\$ 23,241	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.

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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	<b>TOTAL</b>		\$	\$	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: 01/01/2015 Ending: 12/31/2015  
**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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.



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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A-3	hrs	\$		\$	266,320	\$		\$	266,320	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs				102,980				102,980	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A-3	hrs				354,892				354,892	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-3	# of prescripts				193,398				193,398	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Lab</u>	39-3					15,584				15,584	12
13	Other (specify):											13
14	<b>TOTAL</b>			\$		\$	933,174	\$		\$	933,174	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.

Facility Name & ID Number Carlyle Healthcare Center# 0010660Report Period Beginning: 01/01/2015

Ending:

12/31/2015

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (198,317)	\$ (189,605)	1
2	Cash-Patient Deposits	6,233	(44,387)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,699,445	1,699,445	3
4	Supply Inventory (priced at <u>FIFO</u> )	23,425	23,425	4
5	Short-Term Investments	328,846	328,846	5
6	Prepaid Insurance	88,767	91,109	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,948,399	\$ 1,908,833	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	115,450	128,950	13
14	Buildings, at Historical Cost	2,902,045	6,731,673	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,287,037	1,776,366	16
17	Accumulated Depreciation (book methods)	(2,685,324)	(4,253,415)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,619,208	\$ 4,383,574	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,567,607	\$ 6,292,407	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 207,764	\$ 207,764	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,989	226,337	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,804	56,695	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(1,780)	(1,780)	35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 462,777	\$ 489,016	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	467,036	467,036	39
40	Mortgage Payable	993,972	2,715,771	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>line of credit</u>	200,000	200,000	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,661,008	\$ 3,382,807	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,123,785	\$ 3,871,823	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,443,822	\$ 2,420,584	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,567,607	\$ 6,292,407	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,392,867</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2014 Adjustments</b>	<b>(32,292)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,360,575</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(5,405)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>other divisions</b>	<b>65,414</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>60,009</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,420,584</b>	<b>24</b> *

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

Facility Name & ID Number Carlyle Healthcare Center# 0010660Report Period Beginning: 01/01/2015Ending: 12/31/2015

**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.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,798,579	1
2	Discounts and Allowances for all Levels	(16,663)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,781,916	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	384,815	6
7	Oxygen	5	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 384,820	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	1,856	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	27	12
13	Barber and Beauty Care	19,843	13
14	Non-Patient Meals	10,011	14
15	Telephone, Television and Radio	4,818	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	1,171	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,080	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 38,806	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,180	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,180	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Admissions income</b>	2,775	28
28a	<b>See Attached</b>	18,261	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 21,036	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,240,758	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,227,545	31
32	Health Care	3,485,291	32
33	General Administration	1,663,361	33
<b>B. Capital Expense</b>			
34	Ownership	399,396	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	236,053	35
36	Provider Participation Fee	234,516	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,246,162	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(5,404)	41
42	<b>Income Taxes</b>	7,087	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,683	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,160,023	44
45	Private Pay - Net Inpatient Revenue	2,228,473	45
46	Medicare - Net Inpatient Revenue	2,393,420	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,781,916	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: 01/01/2015

Ending: 12/31/2015

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,976	2,088	\$ 84,655	\$ 40.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,609	24,474	615,060	25.13	3
4	Licensed Practical Nurses	30,864	33,139	688,090	20.76	4
5	CNAs & Orderlies	80,334	85,566	947,281	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,829	4,155	55,000	13.24	8
9	Activity Director	1,662	1,751	25,326	14.46	9
10	Activity Assistants	5,868	6,133	60,079	9.80	10
11	Social Service Workers	2,991	3,152	49,764	15.79	11
12	Dietician					12
13	Food Service Supervisor	1,487	1,558	35,556	22.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,721	8,430	98,647	11.70	15
16	Dishwashers	15,636	16,511	156,000	9.45	16
17	Maintenance Workers	6,798	7,432	111,030	14.94	17
18	Housekeepers	11,689	12,525	127,086	10.15	18
19	Laundry	7,278	7,834	75,410	9.63	19
20	Administrator	4,048	4,176	199,479	47.77	20
21	Assistant Administrator					21
22	Other Administrative	2,920	2,920	66,634	22.82	22
23	Office Manager	1,984	2,057	33,472	16.27	23
24	Clerical	4,474	4,853	73,277	15.10	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) <u>Marketing</u>	1,534	1,610	32,140	19.96	33
34	TOTAL (lines 1 - 33)	215,702	230,364	\$ 3,533,986 *	\$ 15.34	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	298	\$ 14,569	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	7,051	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		2,644	11-3	44
45	Social Service Consultant	53	1,669	12-3	45
46	Other(specify)				46
47	<u>Religious</u>		17,640	11-3	47
48					48
49	TOTAL (lines 35 - 48)	543	\$ 49,573		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	608	13,396	10-3	52
53	TOTAL (lines 50 - 52)	608	\$ 13,396		53

Facility Name & ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Gina Higgins	Administrator		\$ 93,779	Workers' Compensation Insurance	\$ 148,770	IDPH License Fee	\$ 1,990		
Chris Reis	Operations		105,700	Unemployment Compensation Insurance	43,466	Advertising: Employee Recruitment	41,831		
				FICA Taxes	263,540	Health Care Worker Background Check	5,324		
				Employee Health Insurance	120,204	(Indicate # of checks performed <u>74</u> )			
				Employee Meals	672	Patient Background Checks	138		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	67,566		
				Employee physicals	11,198	Subscriptions	5,377		
				401K Plan	7,661	Corp fees	1,068		
				non allow officer ins	(5,483)	IHCA	8,306		
						see pg 6	1,477		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 199,479			Less: Public Relations Expense	( )		
B. Administrative - Other						Non-allowable advertising	(67,566)		
Description			Amount			Yellow page advertising	(641)		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Herman Bodewes	Legal		27,578			\$	Out-of-State Travel	\$	
Sigmacare	EMR		34,808						
WDM Computer	Act/Data proces/IT support		90,474				In-State Travel		
WDM Health Services	Management		214,300				see attached list	21,175	
see page 6			(169,714)				Seminar Expense		
non allow			(90,474)						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 106,972	TOTAL		\$	Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 21,175	

\* Attach copy of IMRF notifications

\*\*See instructions.

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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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 8306
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes IHCA 641 If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,046 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. \$ 234,516  
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.

- (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. \$ 672 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,011
- (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) 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.