FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

I. Facility ID Number: 1000071

Facility Name: Villa Catherine

Address: 1070 6th Street (Number) Carlyle (City) 62231 (Zip Code)

County: Clinton

Telephone Number: (618-) 594-8383 **Fax #** 618 594-8384

Federal Employer ID Number:

Date Current Owners were Certified: 01/09/2007

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: David 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 01-01-2016 to 12-31-2016 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) David Reis, President
(Firm Name & Address) WDM Support Services, 1900 Harrison Street Quincy, Illinois 62301
(Telephone) 217 228-1950 Fax 217-222-6053

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

Facility Name Villa Catherine Report Period Beginning: 01-01-2016 Ending: 12-31-2016

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	15	Single Unit Apartment	15	5,490	1
2	2	Double Unit Apartment	2	732	2
3		Other			3
4	17	TOTALS	17	6,222	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	2,714	2,833		5,547	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,714	2,833		5,547	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.15%

D. Indicate the number of paid bed-hold days the SLF had during this year 95 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** _____ **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?
YES [ ] NO [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [X] NO [ ]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 2016 **Fiscal Year:**
*** All facilities other than governmental must report on the accrual basis.**

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? N/A **If yes, did the facility make all of the required payments of interest and principle?** _____
If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? N/A **If yes, did the facility make all of the required payments of interest and principle?** _____
If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? N/A **If yes, did the facility make all of the required payments of interest and principle?** _____
If no, explain.

Facility Name: Villa Catherine **Report Period Beginning: 01-01-2016 Ending: 12-31-2016**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase		32,821	1,650	34,471	(125)	34,346	1
2	Housekeeping, Laundry and Maintenance	11,347	4,275	11,096	26,718	(752)	25,966	2
3	Heat and Other Utilities			16,851	16,851		16,851	3
4	Other (specify):							4
5	**TOTAL General Services**	11,347	37,096	29,597	78,040	(877)	77,163	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	151,774	148		151,922		151,922	6
7	Activities and Social Services		1,050		1,050		1,050	7
8	Other (specify): Beauty/Barber			4,303	4,303	(4,068)	235	8
9	**TOTAL Health Care and Programs**	151,774	1,198	4,303	157,275	(4,068)	153,207	9
	C. General Administration							
10	Administrative and Clerical	25,787	5,793	26,804	58,384		58,384	10
11	Marketing Materials, Promotions and Advertising			2,315	2,315		2,315	11
12	Employee Benefits and Payroll Taxes			15,665	15,665		15,665	12
13	Insurance-Property, Liability and Malpractice			14,425	14,425		14,425	13
14	Other (specify):							14
15	**TOTAL General Administration**	25,787	5,793	59,209	90,789		90,789	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	188,908	44,087	93,109	326,104	(4,945)	321,159	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			48,770	48,770		48,770	17
18	Interest			43,451	43,451	(9)	43,442	18
19	Real Estate Taxes			22,972	22,972		22,972	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Transportation			177	177		177	22
23	**TOTAL Ownership**			115,370	115,370	(9)	115,361	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	188,908	44,087	208,479	441,474	(4,954)	436,520	24

Facility Name: Villa Catherine Report Period Beginning: 01-01-2016 Ending: 12-31-2016

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 18.71	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	1	11.04	3
4	Activity Director & Assistants	1	11.04	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1	11.04	7
8	Dishwashers			8
9	Maintenance Workers	1	11.64	9
10	Housekeepers	1	11.04	10
11	Laundry			11
12	Managers	1	23.64	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	7	$ 12.50	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	1
2			2
	Total	$	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
Carlyle Healthcare	Carlyle	WDM Health Services Inc.	Quincy	Mgmt
St. Vincent's Home	Quincy			
Southern Illinois Living Center	New Baden			

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [ ] NO [X]
Name of related entity: _____ If yes, what is the value of those services? $ _____
(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES [X] NO [ ]
If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Villa Catherine Report Period Beginning: 01-01-2016 Ending: 12-31-2016

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired 1969

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	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	
1	17		2007	2006	$ 1,302,304	$ 47,469	28	$ 47,469	$	$ 474,470	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Landscaping/fence			2007	14,167	873	15	873		8,695	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 1,316,471	$ 48,342		$ 48,342	$	$ 483,165	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	$ 62,538	$ 428	$ 428	$	8	$ 53,746	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 62,538	$ 428	$ 428	$		$ 53,746	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: Villa Catherine **Report Period Beginning:** 01-01-2016 **Ending:** 2-31-2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

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? ☐ YES ☐ NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*	
3	Original Building			/ /	$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				$			7

8. Is movable equipment rental included in building rental? ☐ YES ☐ NO

9. Rental amount for movable equipment $ _____

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	First National Bank		X	Mortgage	4/6/12	$ 3,013,000	$ 2,617,385	4/16/17	4.8500	$ 43,451	1
2					/ /			/ /		** see notes	2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 3,013,000	$ 2,617,385			$ 43,451	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 3,013,000	$ 2,617,385			$ 43,451	10

* If there is an option to buy the building, please provide complete details on an attached schedule.
** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Villa Catherine **Report Period Beginning:** 01-01-2016 **Ending:** 12-31-2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2016 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,924	$ (346,448)	1
2	Cash-Patient Deposits	(12,700)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,191,852	3
4	Supply Inventory (priced at)		23,425	4
5	Short-Term Investments		328,852	5
6	Prepaid Insurance		42,696	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,776)	$ 2,240,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		128,950	13
14	Buildings, at Historical Cost	1,316,471	6,948,908	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	62,538	1,765,475	16
17	Accumulated Depreciation (book methods)	(536,911)	(4,583,953)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 842,098	$ 4,259,380	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 838,322	$ 6,499,757	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 252,881	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		20,985	29
30	Accrued Salaries Payable	4,848	229,722	30
31	Accrued Taxes Payable		54,422	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 4,848	$ 558,010	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		3,444,068	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$	$ 3,444,068	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 4,848	$ 4,002,078	45
46	**TOTAL EQUITY**	$ 833,474	$ 2,497,679	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 838,322	$ 6,499,757	47

***(See instructions.)**

Facility Name: Villa Catherine **Report Period Beginning: 01-01-2016 Ending: 12-31-2016**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 510,261	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 510,261	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	8,728	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	4,068	8
9	Non-Resident Meals	125	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 12,921	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	9	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 9	14
	D. Other Revenue (specify):		
15	**Avtivities**	409	15
16	**television/cable**	752	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 1,161	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 524,352	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	78,040	19
20	Health Care/ Personal Care	157,275	20
21	General Administration	90,789	21
	B. Capital Expense		
22	Ownership	115,370	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 441,474	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 82,878	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 82,878	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 245,795	32
33	Private Pay - Net Inpatient Revenue	264,466	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 510,261	37

Interest expense is based on a allocation of the current interest rate on the portion of the debt
of the supportive living facility.

Page 4 Schedule VII A

Sue Gray owns 50% Carlyle Healthcare Inc
Ann Reis owns 50% Carlyle Healthcare Inc
Ann Reis owns 25 % of Clinton Manor Living Center Inc. New Baden, Il

Carlyle Healthcare owns 100% of Villa Catherine Assisted Living a division of Carlyle Healthcare
Carlyle Healthcare owns 100% of Villa Catherine Supportive Living a division of Carlyle Healthcare
Carlyle Healthcare owns 100% of Catherine Kasper Village a division of Carlyle Healthcare

Carlyle Healthcare owns 100% of St. Vincents Home Inc.
Carlyle Healthcare owns 100% of St.Vincents Home Inc.-Casista Catherine Assisted Living
Carlyle Healthcare owns 100% of St. Vincents Home Inc.-Catherine Kasper Village
Carlyle Healthcare owns 100% of St. Vincents Home Inc.-Catherine Kasper Community Center

Sue Gray owns 50% of WDM Health Services Inc.
Ann Reis owns 50%of Wdm Health Services Inc.
No owner salaries are reflected in page 3

Page 4 Schedule VII C
Carlyle Healtcare provides at cost a service for laundry,maint.and refuse disposal.
Carlyle Healthcare also sells at cost to Villa Catherine food and ADM fees

	Carlyle Healthcare Costs	Supportive Living Costs
Food Exp.	$127	$127
Laundry Fee	1080	1080
Maintenance services	11347	11347
Refuse Disposal	10016	10016
Administrative fees	14200	14200

Page 3 line 13 Property Taxes are based on actual assessed value of the propertyby the county. See attached copies for details.

Schedule IV adjustments
line 1 is reduced by food for employee and guest meals.
line 18 is reduced by interest income
line 2 is reduced by telephone/cable income
line 8 is reduced by Beauty/barber income