FOR BHF USE

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

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.

I. IDPH License ID Number: 06610660

Facility Name: Carlyle Healthcare Center Inc.

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	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: 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 01/01/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Karla Diekamper
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) David Reis, President
(Firm Name & Address) WDM Support Services, 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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,521	13,675	4,285	33,481	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,521	13,675	4,285	33,481	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.15%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [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 92 and days of care provided 4,285

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 2018 Fiscal Year: _____

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,310	21,849	13,130	271,289		271,289		271,289			1
2	Food Purchase		234,073		234,073		234,073	(7,301)	226,772			2
3	Housekeeping	141,027	33,656		174,683		174,683		174,683			3
4	Laundry	57,777	17,538	2,036	77,351		77,351	(1,080)	76,271			4
5	Heat and Other Utilities			183,934	183,934		183,934		183,934			5
6	Maintenance	95,976	71,249	30,406	197,631		197,631		197,631			6
7	Other (specify):*											7
8	TOTAL General Services	531,090	378,365	229,506	1,138,961		1,138,961	(8,381)	1,130,580			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	2,462,896	144,676	142,805	2,750,377		2,750,377	(495)	2,749,882			10
10a	Therapy	46,345		818,415	864,760		864,760		864,760			10a
11	Activities	75,608	12,895	21,305	109,808		109,808		109,808			11
12	Social Services	56,918		1,667	58,585		58,585		58,585			12
13	CNA Training											13
14	Program Transportation		3,839		3,839		3,839	(3,839)				14
15	Other (specify):* sales tax			4,859	4,859		4,859	(4,859)				15
16	TOTAL Health Care and Programs	2,641,767	161,410	995,051	3,798,228		3,798,228	(9,193)	3,789,035			16
	C. General Administration											
17	Administrative	205,917			205,917		205,917		205,917			17
18	Directors Fees											18
19	Professional Services			436,626	436,626		436,626	(275,277)	161,349			19
20	Dues, Fees, Subscriptions & Promotions			66,441	66,441		66,441	(29,584)	36,857			20
21	Clerical & General Office Expenses	266,502	28,923	27,348	322,773		322,773	2,576	325,349			21
22	Employee Benefits & Payroll Taxes			611,997	611,997		611,997	(4,712)	607,285			22
23	Inservice Training & Education			3,402	3,402		3,402		3,402			23
24	Travel and Seminar			14,460	14,460		14,460	416	14,876			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,606	77,606		77,606		77,606			26
27	Other (specify):*											27
28	TOTAL General Administration	472,419	28,923	1,237,880	1,739,222		1,739,222	(306,581)	1,432,641			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,645,276	568,698	2,462,437	6,676,411		6,676,411	(324,155)	6,352,256			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 Inc. #06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			206,487	206,487		206,487	(5,766)	200,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,669	84,669		84,669	(16,562)	68,107			32
33	Real Estate Taxes			55,574	55,574		55,574		55,574			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,440	2,440		2,440		2,440			35
36	Other (specify):* Bad Debts			79,273	79,273		79,273	(79,273)				36
37	TOTAL Ownership			428,443	428,443		428,443	(101,601)	326,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			188,614	188,614		188,614		188,614			39
40	Barber and Beauty Shops			14,764	14,764		14,764		14,764			40
41	Coffee and Gift Shops		1,589		1,589		1,589		1,589			41
42	Provider Participation Fee			241,936	241,936		241,936		241,936			42
43	Other (specify):* Penalty			9,393	9,393		9,393	(9,393)				43
44	TOTAL Special Cost Centers		1,589	454,707	456,296		456,296	(9,393)	446,903			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,645,276	570,287	3,345,587	7,561,150		7,561,150	(435,149)	7,126,001			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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,972)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(495)	10		7
8	Laundry for Non-Patients	(1,080)	4		8
9	Non-Straightline Depreciation	(4,500)	30		9
10	Interest and Other Investment Income	(16,562)	32		10
11	Discounts, Allowances, Rebates & Refunds	(329)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,859)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(114,444)	19		15
16	Personal Expenses (Including Transportation)	(3,839)	14		16
17	Non-Care Related Fees	(701)	20		17
18	Fines and Penalties	(9,393)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(4,712)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,273)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(28,883)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (276,042)		$	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)	(157,841)		34
35	Other- Attach Schedule	(1,266)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (159,107)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (435,149)		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 Inc.

ID# 06610660

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Audit 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
18				18
19				19
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22				22
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27				27
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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**	(1,266)		49

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ann Reis	45	St Vincent's Home	Quincy	WDM Health Services Inc.		Management
Chris Reis	5	Clinton Manor	New Baden			
Sue Gray	50					

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	$ 217,800	WDM Health Services Inc.	0.00%	$ 52,532	$ (165,268)	1
2	V	19	Accounting				2,683	2,683	2
3	V	19	Legal				1,752	1,752	3
4	V	20	Subscriptions						4
5	V	21	Office				2,490	2,490	5
6	V	21	Postage				86	86	6
7	V	24	Travel				416	416	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 217,800			$ 59,959	$ * (157,841)	14

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ann Reis	Secretary	Carlyle	45.00		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 Healthcare owns 100% of the St. Vincents Stock			100.00							7
8	WDM Health Services							Mgmt Fee	217,800	19-3	8
9	Janeane Reis	HR director	Carlyle/St Vincents		49,945			Wages	64,281	22-1	9
10	Ann Reis		Southern Ill Livg Ctr			2	4.00				10
11	Chris Reis	VP Operations	Carlyle/St Vincents	5.00	32,026			Wages	113,538	17-1	11
12											12
13								TOTAL	$ 395,619		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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: WDM Health Services Inc.
Street Address: 1900 Harrison Street
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	60,261	2	$ 94,550	$ 94,550	33,481	$ 52,532	1
2	19	Accounting	Patient Days	60,261	2	4,829		33,481	2,683	2
3	19	Legal	Patient Days	60,261	2	3,153		33,481	1,752	3
4	19	Subscriptions	Patient Days	60,261	2	0		33,481	0	4
5	21	Office	Patient Days	60,261	2	4,481		33,481	2,490	5
6	21	Postage	Patient Days	60,261	2	155		33,481	86	6
7	24	Travel	Patient Days	60,261	2	748		33,481	416	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					$ 107,916	$ 94,550		$ 59,959	25

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First national Bank		X	Mortgage	$19,000.00	04/16/17	$ 3,013,000	$ 2,405,876	04/16/22	4.8500	$ **39420	1
2	First national Bank		X	2nd Mortgage	$3,300.00	12/17/18	500,000	412,485	12/16/21	5.3000	20,449	2
3												3
4												4
5												5
	Working Capital											
6	First national Bank		X	Line of Credit		01/27/18	270,000		01/07/19	4.7500	14,838	6
7	First national Bank		X	Generators	$4,820.00	11/02/17	260,000		11/02/22	4.2500	9,962	7
8												8
9	TOTAL Facility Related				$27,120.00		$ 4,043,000	$ 2,818,361			$ 84,669	9
	B. Non-Facility Related*											
10	Interest Income										(16,562)	10
11	** Interest expense is based on the actual cost to the nursinh home debt. Other interest is to Supportive and Assisted living.											11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,562)	14
15	TOTALS (line 9+line14)						$ 4,043,000	$ 2,818,361			$ 68,107	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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	57,219	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2017 111589	2
3. Under or (over) accrual (line 2 minus line 1).	$	54,370	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	55,565	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.	$	**55574	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	113,701	8
	2014	113,396	9
	2015	112,985	10
	2016	111,261	11
	2017	111,589	12

** Property tax allocated to the Nursing Home (see attached worksheet)

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

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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlyle Healthcare Center Inc. COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 06610660

CONTACT PERSON REGARDING THIS REPORT Karla Diekamper

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-18-353-005	Nursing Home	$ 110,725.81	$ 54,710.49
2.	08-08-18-353-004	Nursing Home	$ 86,319.00	$ 863.19
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 197,044.81	$ 55,573.68

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

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 Catherin Assisted Living 18 units 15737 sq feet
Villa Catherin Supportive Living 17units 12000 sq feet
Casper Kasper Village 13 independent cottages 18000 sq feet

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	34		1969	1969	$ 30,426	$	30	$	$	$ 30,426	4
5	4		1988	1988	99,400	3,055	30	3,055		99,400	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		346,909	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			3,288	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		30			319,491	23
24	ROOM REMODELING			1988	16,596	510	30	510		16,596	24
25	ROOM REMODELING			1989	1,948	65	30	65		1,948	25
26	WINDOWS			1989	3,230	136	30	136		3,230	26
27	ROOF			1989	11,294	386	30	386		11,294	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		33			85,961	32
33	ELEVATOR			1997	83,288		20			83,288	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 & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOOR TILE	1995	$ 7,178	$	15	$	$	$ 7,178	37
38	FLOOR CORRECTION	1999	28,360	1,425	20	1,425		28,003	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		29,827	41
42	LANDSCAPING	2001	20,000		15			20,000	42
43	CONCRETE LOT/LIGHTING	2001	25,100		15			25,100	43
44	WINDOWS	2001	82,000	4,120	20	4,120		70,672	44
45	CENTER ROOF	2003	29,822	1,498	20	1,498		23,831	45
46	DINNING ROOM WINDOWS	2003	41,266	2,072	20	2,072		31,940	46
47	NEW PATIO	2003	73,579	3,696	20	3,696		58,486	47
48	SPRINKLER WALKINCOOLER/PATIO	2003	7,524	376	20	376		5,987	48
49	LOADING DOCK LIFT	2003	16,905	95	15	95		16,905	49
50	HOT WATER HTR	2004	3,285		8			3,285	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	353	15	353		4,912	51
52	TUCKPOINTING	2004	6,835		10			6,835	52
53	TRANSFORMER FOR BUILDING	2004	15,008	756	20	756		10,785	53
54	SPRINKLER MIDDLE SECTION	2004	63,606	3,181	20	3,181		44,785	54
55	SOUTH CENTER SECTION ROOF	2005	13,800	920	15	920		12,573	55
56	KITCHEN HOOD/EXHAUST SYSTEM	2005	21,763	1,088	20	1,088		14,871	56
57	FIRE SURPRESSION SYSTEM/HOOD	2005	3,114	208	15	208		2,837	57
58	DOUBLE DOORS TO ALHZIEMERS WING	2005	2,103		8			2,103	58
59	HOSPITSLITY CENTER	2005	2,922		8			2,922	59
60	KITCHEN REMODELING	2005	47,007	2,856	20	2,342	(514)	35,608	60
61	17 TREES	2005	7,613	380	20	380		4,980	61
62	DISHERWASHER ROOM REMODELING	2006	4,561	212	20	212		3,020	62
63	FIRST FLOOR DINNING ROOM REMODEL	2006	9,488	633	15	633		8,012	63
64	WONDER GUARD	2006	26,316		15			26,026	64
65	3 CENTRAL HTG/AC UNITS	2006	26,026	1,735	15	1,735		21,255	65
66	WATER SOFTNER	2006	2,995		8			2,995	66
67	NEW ROOF FIRST FL&CHAPEL	2007	9,859	493	20	493		5,751	67
68	2ND FLOOR KITCHEN	2007	5,377	269	20	269		3,114	68
69	HANDRAILS	2007	8,072	538	15	538		6,009	69
70	TOTAL (lines 4 thru 69)		$ 2,366,597	$ 46,183		$ 45,669	$ (514)	$ 2,186,786	70

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,366,597	$ 46,183		$ 45,669	$ (514)	$ 2,186,786	1
2	Landscaping	2008	8,558	428	20	428		4,528	2
3	Front Sign	2009	17,926	1,195	15	1,195		11,951	3
4	Elevator improvmts	2009	8,679	579	15	579		5,738	4
5	South wing SPA	2009	27,148	1,035	30	900	(135)	9,464	5
6	Front Lot Lidgts	2009	35,929	2,395	15	2,395		23,154	6
7	South Wing Roof	2009	38,900	1,970	20	1,970		18,055	7
8	2nd Floor Spa	2010	15,874	529	30	529		4,365	8
9	Front Landscaping	2010	19,768	1,318	15	1,318		11,311	9
10	Kitchen A/C	2010	6,753	450	15	450		3,864	10
11	Elevator to code	2012	157,456	5,251	30	5,251		35,811	11
12	2nd Floor Dinnng Room A/C	2012	4,443	555	8	555		3,702	12
13	Hazard Waste Garage	2012	1,599	200	8	200		1,316	13
14	RF wonder guard/door locking	2012	260,968	17,449	15	17,275	(174)	109,816	14
15	Stairwell Plastering	2013	10,790	552	20	552		2,865	15
16	2nd floor ceiling /plastering	2013	102,640	5,362	20	5,094	(268)	84,737	16
17	Middle section new steel roof	2013	133,290	6,732	20	6,665	(67)	33,392	17
18	West wing flooringand ceiling tile	2013	51,783	2,710	20	2,602	(108)	13,344	18
19	tucker electric panel materials/labor	2016	40,101	2,676	15	2,676		7,766	19
20	carlyle transformer	2016	7,030	468	15	468		1,250	20
21	Koeman masonary work	2016	9,968	667	15	667		1,746	21
22	Gestner cast iron pipe	2016	5,351	357	15	357		951	22
23	Patio for Generators	2017	26,417	440	15	440		2,301	23
24	2 new Generators	2017	200,117	13,341	15	13,341		14,453	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)		$ 3,558,085	$ 112,842		$ 111,576	$ (1,266)	$ 2,592,666	34

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

Facility Name & ID Number Carlyle Healthcare Center Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 708,788	$ 78,382	$ 78,382	$	8	$ 432,306	71
72	Current Year Purchases	84,375	5,624	5,624		8	5,624	72
73	Fully Depreciated Assets	150,699					150,699	73
74								74
75	TOTALS	$ 943,862	$ 84,006	$ 84,006	$		$ 588,629	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	Resdents Transportation	2013 Dodge Van	2012	$ 27,569	$	$	$	5	$ 27,569	76
77	Resdents Transportation	2016 Chev Equinox	2016	25,696	5,139	5,139		5	15,418	77
78										78
79										79
80	TOTALS			$ 53,265	$ 5,139	$ 5,139	$		$ 42,987	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)	$ 4,658,712	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,987	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 200,721	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)	$ 3,224,282	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	$ 4,500	$ 32,243	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 73,331	$ 4,500	$ 32,243	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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	$		$ 287,279	$		$ 287,279	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			171,451			171,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			359,685			359,685	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 prescrpts				160,796		160,796	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					13,771		13,771	12
13	Other (specify): Radiology	39-3					14,047		14,047	13
14	TOTAL			$		$ 818,415	$ 188,614		$ 1,007,029	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 Inc. # 06610660 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (172,110)	$ (172,110)	1
2	Cash-Patient Deposits	3,140	3,140	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,814,272	1,814,272	3
4	Supply Inventory (priced at)	30,331	30,331	4
5	Short-Term Investments	329,447	329,447	5
6	Prepaid Insurance	51,207	51,207	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)**	$ 2,056,287	$ 2,056,287	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	115,450	288,950	13
14	Buildings, at Historical Cost	2,977,051	6,934,395	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,678,897	2,176,862	16
17	Accumulated Depreciation (book methods)	(3,232,508)	(5,140,003)	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		309,376	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,538,890	$ 4,569,580	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,595,177	$ 6,625,867	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 150,524	$ 150,524	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,706	10,706	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	246,395	254,255	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,565	71,816	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(20,000)	(20,000)	35
	Other Current Liabilities(specify):			
36	Deferred Income		271,200	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 443,190	$ 738,501	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	412,485	412,486	39
40	Mortgage Payable	890,174	2,405,876	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Generator loan		208,301	43
44	Line of Credit	260,475	260,475	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,563,134	$ 3,287,138	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,006,324	$ 4,025,639	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,588,853	$ 2,600,228	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,595,177	$ 6,625,867	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,529,514	1
2	Restatements (describe):		2
3	prior year adj	(1,324)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,528,190	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,785	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	253	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 72,038	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,600,228	24 *

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

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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	$ 7,188,189	1
2	Discounts and Allowances for all Levels	(75,609)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,112,580	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	458,581	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 458,581	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	340	12
13	Barber and Beauty Care	12,737	13
14	Non-Patient Meals	5,910	14
15	Telephone, Television and Radio	3,080	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	495	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,080	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,642	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,562	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,562	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Admissions	3,086	28
28a	see attached list	18,484	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,570	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,632,935	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,138,961	31
32	Health Care	3,798,228	32
33	General Administration	1,739,222	33
	B. Capital Expense		
34	Ownership	428,443	34
	C. Ancillary Expense		
35	Special Cost Centers	214,360	35
36	Provider Participation Fee	241,936	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,561,150	40
41	**Income before Income Taxes (line 30 minus line 40)****	71,785	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 71,785	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,152,072	44
45	Private Pay - Net Inpatient Revenue	2,711,096	45
46	Medicare - Net Inpatient Revenue	2,249,412	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,112,580	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.**

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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	1,944	2,088	$ 90,781	$ 43.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,861	14,771	392,260	26.56	3
4	Licensed Practical Nurses	36,036	39,152	887,185	22.66	4
5	CNAs & Orderlies	85,540	90,285	1,092,669	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,031	3,103	46,346	14.94	8
9	Activity Director	1,941	2,088	31,116	14.90	9
10	Activity Assistants	4,254	4,421	44,492	10.06	10
11	Social Service Workers	3,677	3,943	56,918	14.44	11
12	Dietician					12
13	Food Service Supervisor	2,384	2,547	41,191	16.17	13
14	Head Cook	3,038	3,096	39,657	12.81	14
15	Cook Helpers/Assistants	14,471	15,085	155,463	10.31	15
16	Dishwashers					16
17	Maintenance Workers	5,650	5,730	95,976	16.75	17
18	Housekeepers	12,057	12,732	141,027	11.08	18
19	Laundry	5,344	5,810	57,777	9.94	19
20	Administrator	1,961	2,088	92,238	44.18	20
21	Assistant Administrator	2,088	2,088	63,881	30.59	21
22	Other Administrative	2,088	2,088	113,679	54.44	22
23	Office Manager	435	435	7,825	17.99	23
24	Clerical	7,838	8,534	140,873	16.51	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) Marketing	1,904	2,088	53,922	25.82	33
34	TOTAL (lines 1 - 33)	209,542	222,172	$ 3,645,276 *	$ 16.41	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	239	$ 13,130	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	192	11,199	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		31,151	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	2,465	11-3	44
45	Social Service Consultant		1,667	12-3	45
46	Other(specify) religious	26	18,840	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	484	$ 84,452		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	6,278	100,455	10-3	52
53	TOTAL (lines 50 - 52)	6,278	$ 100,455		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina Higgins	Administrator		$ 27,886
Chris Reis	VP operations	5	113,679
Karla Diekamper	Administrator		64,352
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 205,917

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	$ 7,483
SB2	Legal	50,349
WDM Support Services	Act/IT/Pr	114,444
WDM Health Services Inc.	Managemnet	217,800
Sigmacare	EMH	46,551
Non Allow		(114,444)
see pg 6		(160,834)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 161,349

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,656
Unemployment Compensation Insurance	32,246
FICA Taxes	272,862
Employee Health Insurance	187,778
Employee Meals	405
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	10,200
Officers ins	4,712
401K plan expenses	4,138
non allow	(4,712)
TOTAL (agree to Schedule V, line 22, col.8)	$ 607,285

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	19,950
Health Care Worker Background Check	3,021
(Indicate # of checks performed 26)	
Patient Background Checks 130	
subscriptions	2,969
IHCA	8,318
sec of state	1,310
Advertising	28,883
PAC dues	(701)
Less: Public Relations Expense	( )
Non-allowable advertising	(28,883)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
see list	14,460
see pg 6	416
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,876

**See instructions.

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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 8318**

(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? **701**

(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. $ **25,510** 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? **N**
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. $ **241,936**
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. $ **405** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,972**

(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?
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