

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0010660

**Facility Name:** Carlyle Healthcare Center

**Address:** 501 Clinton Street Carlyle 62231  
 Number City Zip Code

**County:** Clinton

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

**HFS ID Number:** 37-0997048001

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

**Type of Ownership:**

<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 _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Dave Reis **Telephone Number:** 217-228-1950

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	
	(Date) _____	
	(Print Name and Title)	<u>David Reis</u> <u>President</u>
	(Firm Name & Address)	<u>WDM Computer Services Inc.</u> <u>1900 Harrison Street Quincy, Ill 62301</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		

Facility Name & ID Number Carlyle Healthcare Center

# 0010660 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 05/25/2006

	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	<u>51</u>	Skilled (SNF)	<u>99</u>	<u>29,223</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>20</u>	<u>14,212</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	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	<u>18,494</u>		<u>3,391</u>	<u>21,885</u>	8
9	SNF/PED					9
10	ICF		<u>12,251</u>		<u>12,251</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,494</u>	<u>12,251</u>	<u>3,391</u>	<u>34,136</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.59%

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)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 63 and days of care provided 3,391

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 2006 Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	247,732	13,549	6,611	267,892		267,892		267,892			1
2	Food Purchase		187,224		187,224	(1,825)	185,399	(6,297)	179,102			2
3	Housekeeping	116,166	21,766		137,932		137,932		137,932			3
4	Laundry	77,939	14,559	615	93,113		93,113		93,113			4
5	Heat and Other Utilities			139,259	139,259		139,259		139,259			5
6	Maintenance	126,527	18,008	42,458	186,993		186,993		186,993			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	568,364	255,106	188,943	1,012,413	(1,825)	1,010,588	(6,297)	1,004,291			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,720	3,720		3,720		3,720			9
10	Nursing and Medical Records	1,453,262	190,233	4,980	1,648,475		1,648,475	(15,041)	1,633,434			10
10a	Therapy	73,220	3,745	378,079	455,044		455,044		455,044			10a
11	Activities	95,819	8,358	24,312	128,489		128,489		128,489			11
12	Social Services	22,726		2,576	25,302		25,302		25,302			12
13	CNA Training											13
14	Program Transportation	5,267	1,811		7,078		7,078	(3,716)	3,362			14
15	Other (specify):* <b>Contributions</b>			785	785		785	(785)				15
16	<b>TOTAL Health Care and Programs</b>	1,650,294	204,147	414,452	2,268,893		2,268,893	(19,542)	2,249,351			16
	<b>C. General Administration</b>											
17	Administrative	176,708			176,708		176,708	(50,000)	126,708			17
18	Directors Fees											18
19	Professional Services			360,670	360,670		360,670	(298,179)	62,491			19
20	Dues, Fees, Subscriptions & Promotions			31,852	31,852		31,852	(26,697)	5,155			20
21	Clerical & General Office Expenses	111,027	18,046	14,912	143,985		143,985	67	144,052			21
22	Employee Benefits & Payroll Taxes			341,942	341,942	1,825	343,767	(6,890)	336,877			22
23	Inservice Training & Education			115	115		115		115			23
24	Travel and Seminar			7,455	7,455		7,455		7,455			24
25	Other Admin. Staff Transportation		1,811		1,811		1,811		1,811			25
26	Insurance-Prop.Liab.Malpractice			89,777	89,777		89,777		89,777			26
27	Other (specify):* <b>Sales Taxes</b>			3,777	3,777		3,777	(3,777)				27
28	<b>TOTAL General Administration</b>	287,735	19,857	850,500	1,158,092	1,825	1,159,917	(385,476)	774,441			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,506,393	479,110	1,453,895	4,439,398		4,439,398	(411,315)	4,028,083			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: 01/01/2006 Ending: 12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			139,435	139,435		139,435	1,541	140,976			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,631	40,631		40,631	(15,960)	24,671			32
33	Real Estate Taxes			39,002	39,002		39,002		39,002			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			828	828		828		828			35
36	Other (specify):* <b>Penalty</b>			5,008	5,008		5,008	(5,008)				36
37	<b>TOTAL Ownership</b>			224,904	224,904		224,904	(19,427)	205,477			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,318		5,318		5,318	(5,318)				39
40	Barber and Beauty Shops		714	15,176	15,890		15,890		15,890			40
41	Coffee and Gift Shops		17,614		17,614		17,614	(3,468)	14,146			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* <b>Bad Debts</b>			20,468	20,468		20,468	(20,468)				43
44	<b>TOTAL Special Cost Centers</b>		23,646	100,797	124,443		124,443	(29,254)	95,189			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,506,393	502,756	1,779,596	4,788,745		4,788,745	(459,996)	4,328,749			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: 01/01/2006

Ending: 12/31/2006

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(5,318)	39		3
4	Non-Patient Meals	(5,836)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(15,041)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,541	30		9
10	Interest and Other Investment Income	(15,960)	32		10
11	Discounts, Allowances, Rebates & Refunds	(461)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,777)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(3,468)	41		15
16	Personal Expenses (Including Transportation)	(3,716)	14		16
17	Non-Care Related Fees	(57,796)	19		17
18	Fines and Penalties	(5,008)	36		18
19	Entertainment				19
20	Contributions	(785)	15		20
21	Owner or Key-Man Insurance	(6,890)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,468)	43		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	(27,114)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (170,097)		\$	30

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)	(289,899)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (289,899)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (459,996)		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		52

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,297)	0	0	0	0	0	0	0	0	0	0	(6,297)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,297)</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>(6,297)</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	(15,041)	0	0	0	0	0	0	0	0	0	0	(15,041)	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	(3,716)	0	0	0	0	0	0	0	0	0	0	(3,716)	14
15	Other (specify):*	(785)	0	0	0	0	0	0	0	0	0	0	(785)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(19,542)</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>(19,542)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(57,796)	(240,383)	0	0	0	0	0	0	0	0	0	(298,179)	19
20	Fees, Subscriptions & Promotions	(27,114)	417	0	0	0	0	0	0	0	0	0	(26,697)	20
21	Clerical & General Office Expenses	0	67	0	0	0	0	0	0	0	0	0	67	21
22	Employee Benefits & Payroll Taxes	(6,890)	0	0	0	0	0	0	0	0	0	0	(6,890)	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):*	(3,777)	0	0	0	0	0	0	0	0	0	0	(3,777)	27
28	<b>TOTAL General Administration</b>	<b>(95,577)</b>	<b>(289,899)</b>	<b>0</b>	<b>(385,476)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(121,416)</b>	<b>(289,899)</b>	<b>0</b>	<b>(411,315)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlyle Healthcare Center# 0010660 Report Period Beginning:01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,541	0	0	0	0	0	0	0	0	0	0	1,541	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,960)	0	0	0	0	0	0	0	0	0	0	(15,960)	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):*	(5,008)	0	0	0	0	0	0	0	0	0	0	(5,008)	36
37	<b>TOTAL Ownership</b>	<b>(19,427)</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>(19,427)</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	(5,318)	0	0	0	0	0	0	0	0	0	0	(5,318)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(3,468)	0	0	0	0	0	0	0	0	0	0	(3,468)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(20,468)	0	0	0	0	0	0	0	0	0	0	(20,468)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(29,254)</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>(29,254)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(170,097)</b>	<b>(289,899)</b>	<b>0</b>	<b>(459,996)</b>	<b>45</b>								

Facility Name & ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dorothy Messick	51	ST. Vincents Home Inc.	Quincy	WDM Health SCVs	Quincy	MGMT
Ann Reis	24	Clinton Manor	New Baden			
Sue Gray	24					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	19 Management	300,000	WDM Health Services Inc.		57,001	(242,999)	2
3	V	19 Accounting		WDM Health Services Inc.		2,565	2,565	3
4	V	21 Office Supplies		WDM Health Services Inc.		67	67	4
5	V	20 License Fees		WDM Health Services Inc.		57	57	5
6	V	19 Legal		WDM Health Services Inc.		51	51	6
7	V	20 Dues & Subscriptions		WDM Health Services Inc.		360	360	7
8	V							8
9	V							9
10	V	17 Officer Wages	100,000	St. Vincents Home Allocation		50,000	(50,000)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 400,000			\$ 110,101	\$ * (289,899)	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: 01/01/2006 Ending: 12/31/2006

## 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	Dorothy Messick	President	Carlyle	52.00		20	50.00	Wages	\$ 100,000	17-1	1
2	Ann Reis	Secretary	Carlyle	24.00		19	48.00				2
3	Sue Gray	Treasurer	Carlyle	24.00		20	50.00				3
4											4
5	Dorothy Messick	President	St. Vincents			20	50.00				5
6	Ann Reis	Secretary	St. Vincents			19	48.00				6
7	Sue Gray	Treasurer	St. Vincents			20	50.00				7
8											8
9	Carlyle Healthcare owns St. Vincents			100.00							9
10											10
11	WDM Health Services Inc		Management						300,000	19-3	11
12	Ann Reis		Clinton			2	4.00				12
13								TOTAL	\$ 400,000		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: 01/01/2006

Ending: 2/31/2006

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

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

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

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	Managemant Fees	Patient Days	59,887	2	\$ 100,000	\$ 34,136	\$ 57,001	1
2	19	Accounting	Patient Days	59,887	2	4,500	34,136	2,565	2
3	21	Office Supplies	Patient Days	59,887	2	118	34,136	67	3
4	19	Legal	Patient Days	59,887	2	90	34,136	51	4
5	20	Dues & subscriptions	Patient Days	59,887	2	632	34,136	360	5
6	20	License Fees	Patient Days	59,887	2	100	34,136	57	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 105,440	\$ 100,000	\$ 60,101	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First National Bank		X	Mortgage	\$9,500.00	08/19/06	\$ 647,634	\$	11/10/06	5.7500	\$ 31,311	1								
2	First National Bank		X	Mortgage	\$16,200.00	11/10/06	1,952,000	1,947,996	11/10/09	7.2500	5,291	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	First National Bank		X	Equip/Sprinkler Loan	\$1,900.00	12/17/04	100,000		11/10/06	6.0000	4,029	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$27,600.00		\$ 2,699,634	\$ 1,947,996			\$ 40,631	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11				Investment income							(15,960)	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(15,960)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,699,634	\$ 1,947,996			\$ 24,671	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$ 45,554	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.)	2005	45,822	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ 268	3																				
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 45,822	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.		\$ *39002	7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	2001	41,978	8																				
	2002	42,606	9																				
	2003	43,063	10																				
	2004	45,554	11																				
	2005	45,822	12																				
<table border="1"> <thead> <tr> <th colspan="4">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </tbody> </table>				FOR BHF USE ONLY				13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				
* To reflect amount for Nursing Home Only. Based on square footage allocated to Assisted Living and Supportive Living.																							

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0010660

CONTACT PERSON REGARDING THIS REPORT Joann Brave

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 2005 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 2005.

(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>45,317.20</u>	\$ <u>38,497.00</u>
2. <u>08-08-18-353-004</u>	<u>Nursing Home</u>	\$ <u>504.58</u>	\$ <u>504.58</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,821.78</u>	\$ <u>39,001.58</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? X YES \_\_\_\_\_ NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Carlyle Healthcare Center

# 0010660 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 69,374 B. General Construction Type: Exterior Brick Frame Wood, 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).

Krebs Village 11112 SQ FT 6 Buildings or 12 Independent Living Cottages

Villa Catherine Assisted Living 8334 Sq FT 12 units

Villa Catherine Supportive Living 12000 SQ FT 16 Units

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

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:**

A. Land.

	1	2	3	4	
	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>	<b>3</b>

Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	44		1969	1969	\$ 30,426	\$	30	\$	\$	\$ 30,426	4
5	4		1988	1988	99,400	3,332	30	3,332		59,690	5
6	1		1977	1977	21,293	737	30	737		21,171	6
7	25		1973	1973	138,148		30			138,148	7
8	3		1993	1993	399,471	13,420	30	13,420		185,869	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	367	30	367		10,383	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	1,907	20	1,907		36,921	21
22		BUILDING IMPVMT		1988	30,824		20	1,541	1,541	28,251	22
23		BUILDING ADTN GLASS ENCLOSER		1986	319,491	10,721	30	10,721		214,071	23
24		ROOM REMODELING		1988	16,596	556	30	556		9,966	24
25		ROOM REMODELING		1989	1,948	66	30	66		1,163	25
26		WINDOWS		1989	3,230	109	30	109		1,898	26
27		ROOF		1989	11,294	386	30	386		6,661	27
28		SMOKE DET		1980	2,204		8			2,204	28
29		BUILDING IMPVMT		1993	4,932		10			4,932	29
30		HANDRAILS		1991	6,574		8			6,574	30
31		CUBICLE CURTAINS		1992	8,415		10			8,415	31
32		FRONT PORCH ADTN		1997	85,961	2,595	33	2,595		23,896	32
33		ELEVATOR		1997	83,288	4,190	20	4,190		37,548	33
34		LANDSCAPING/RAILING		1997	8,550	575	15	575		5,145	34
35		LAND IMPROVMTS		1993	51,227	3,508	15	3,508		45,445	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:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	\$ 487	15	\$ 487	\$	\$ 5,268	37
38	FLOOR CORRECTION	1999	28,360	1,425	20	1,425		10,898	38
39	HALLWAY REMODELING	1999	10,315	1,048	15	1,048		7,781	39
40	NEW ROOF CTR/BOILER	2000	19,203	1,557	15	1,557		10,252	40
41	NEW GARAGE	2001	51,030	1,707	30	1,707		9,337	41
42	LANDSCAPING	2001	20,000	1,343	15	1,343		7,358	42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,685	15	1,685		9,234	43
44	WINDOWS	2001	82,000	4,120	20	4,120		21,236	44
45	CENTER ROOF	2003	29,822	1,498	20	1,498		5,859	45
46	DINNING ROOM WINDOWS	2003	41,266	2,072	20	2,072		7,074	46
47	NEW PATIO	2003	73,579	3,696	20	3,696		14,133	47
48	SPRINKLER WALKINCOOLER/PATIO	2003	7,524	376	20	376		1,472	48
49	LOADING DOCK LIFT	2003	16,905	1,134	15	1,134		4,338	49
50	HOT WATER HTR	2004	3,285	410	8	410		855	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	353	15	353		766	51
52	TUCKPOINTING	2004	6,835	684	10	684		1,595	52
53	TRANSFORMER FOR BUILDING	2004	15,008	756	20	756		1,712	53
54	SPRINKLER MIDDLE SECTION	2004	63,606	3,181	20	3,181		6,612	54
55	SOUTH CENTER SECTION ROOF	2005	13,800	920	15	920		1,533	55
56	KITCHEN HOOD/EXHAUST SYSTEM	2005	21,763	1,088	20	1,088		1,814	56
57	FIRE SURPRESSION SYSTEM/HOOD	2005	3,114	208	15	208		346	57
58	DOUBLE DOORS TO ALHZIEMERS WING	2005	2,103	266	8	266		398	58
59	HOSPITALITY CENTER	2005	2,922	365	8	365		517	59
60	KITCHEN REMODELING	2005	57,120	2,856	20	2,856		3,332	60
61	17 TREES	2005	7,613	380	20	380		412	61
62	DISHERWASHER ROOM REMODELING	2006	4,561	472	20	472		472	62
63	FIRST FLOOR DINNING ROOM REMODEL	2006	9,488	422	15	422		422	63
64	WONDER GUARD	2006	27,397	1,730	15	1,730		1,730	64
65	3 CENTRAL HTG/AC UNITS	2006	26,026	434	15	434		434	65
66	WATER SOFTNER	2006	2,995	94	8	94		94	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,354,483	\$ 79,236		\$ 80,777	\$ 1,541	\$ 1,313,587	70

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

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 444,051	\$ 38,705	\$ 38,705	\$	8	\$ 234,673	71
72	Current Year Purchases	84,858	14,435	14,435		8	14,435	72
73	Fully Depreciated Assets	33,349					33,349	73
74								74
75	TOTALS	\$ 562,258	\$ 53,140	\$ 53,140	\$		\$ 282,457	75

D. Vehicle Depreciation (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	FACILITY	2004 CHEV BUS	2006	\$ 42,356	\$ 7,059	\$ 7,059	\$	5	\$ 7,059	76
77										77
78										78
79										79
80	TOTALS			\$ 42,356	\$ 7,059	\$ 7,059	\$		\$ 7,059	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,062,597
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,435
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,976
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,541
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,603,103

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	ADM AUTO	\$ 19,172	\$	\$ 19,172	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 19,172	\$	\$ 19,172	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 828

Description: DISHWASHER

(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.

**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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		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)	
<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	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Oxygen</b>						<b>5,318</b>		<b>5,318</b>	13
14	<b>TOTAL</b>			\$		\$	\$ <b>5,318</b>		\$ <b>5,318</b>	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: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 149,967	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	699,528		3
4	Supply Inventory (priced at <u>FIFO</u> )	5,751		4
5	Short-Term Investments	657,339		5
6	Prepaid Insurance	29,464		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>	\$ 1,542,049	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(108,595)		12
13	Land	128,950		13
14	Buildings, at Historical Cost	3,259,967		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	870,394		16
17	Accumulated Depreciation (book methods)	(2,168,992)		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): <u>CIP</u>	1,321,761		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,303,485	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,845,534	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 143,369	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,807		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,346		32
33	Accrued Interest Payable	6,291		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(22,117)		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 326,696	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,947,996		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DEFERRED INCOME TRUSTS</u>	25,340		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,973,336	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,300,032	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,545,502	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,845,534	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,427,944	1
2	Restatements (describe):		2
3	FEDERAL INCOME TAX ADJ PRIOR YEAR	(12,350)	3
4	PRIOR YEAR END ADJUSTMENTS	(16,558)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,399,036	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	64,538	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) <u>OTHER DIVISIONS</u>	81,928	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 146,466	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,545,502	24 *

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

Facility Name & ID Number Carlyle Healthcare Center# 0010660Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,483,696	1
2	Discounts and Allowances for all Levels	27,529	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,511,225	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	225,847	6
7	Oxygen	14,228	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 240,075	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	3,532	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	15,387	12
13	Barber and Beauty Care	16,750	13
14	Non-Patient Meals	4,011	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,975	17
18	Sale of Supplies to Non-Patients	15,041	18
19	Laboratory	5,778	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 62,474	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,960	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,960	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>SEE ATTACHED LIST</u>	23,549	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 23,549	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,853,283	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,012,413	31
32	Health Care	2,268,893	32
33	General Administration	1,158,092	33
<b>B. Capital Expense</b>			
34	Ownership	224,904	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	59,290	35
36	Provider Participation Fee	65,153	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,788,745	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	64,538	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 64,538	43

\* 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: 01/01/2006

Ending:

12/31/2006

**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	2,040	2,136	\$ 51,036	\$ 23.89	1
2	Assistant Director of Nursing	1,659	1,891	42,275	22.36	2
3	Registered Nurses	9,710	10,171	199,497	19.61	3
4	Licensed Practical Nurses	23,703	24,941	421,889	16.92	4
5	CNAs & Orderlies	69,555	73,313	738,565	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,479	5,827	73,220	12.57	8
9	Activity Director	1,984	2,136	27,223	12.74	9
10	Activity Assistants	6,959	7,535	68,596	9.10	10
11	Social Service Workers	2,046	2,131	22,726	10.66	11
12	Dietician	1,341	1,357	14,516	10.70	12
13	Food Service Supervisor	2,001	2,153	23,652	10.99	13
14	Head Cook	9,844	10,521	93,794	8.91	14
15	Cook Helpers/Assistants	9,142	9,658	73,731	7.63	15
16	Dishwashers	6,335	6,675	42,039	6.30	16
17	Maintenance Workers	9,113	9,762	126,527	12.96	17
18	Housekeepers	13,746	14,677	116,166	7.91	18
19	Laundry	8,816	9,468	77,939	8.23	19
20	Administrator	2,088	2,088	76,708	36.74	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	100,000	47.89	22
23	Office Manager	2,051	2,259	31,549	13.97	23
24	Clerical	5,480	5,952	79,478	13.35	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>TRANSPORT</u>	696	716	5,267	7.36	33
34	TOTAL (lines 1 - 33)	195,876	207,455	\$ 2,506,393 *	\$ 12.08	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	130	\$ 6,611	1-3	35
36	Medical Director		3,720	9-3	36
37	Medical Records Consultant	32	3,180	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	1,800	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				44
45	Social Service Consultant	50	2,576	12-3	45
46	Other(specify) <u>Religious</u>		24,312	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	356	\$ 42,199		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				52
53	TOTAL (lines 50 - 52)		\$		53





**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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. \$ 28,050 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. No
- (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. \$ 65,153  
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. \$ 1,825 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,011
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,716  
c. What percent of all travel expense relates to transportation of nurses and patients? 50  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.