

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 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
IRS Exemption Code _____	<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: Davr 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 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

10660 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>20</u>	Intermediate/DD	<u>20</u>	<u>7,300</u>	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>4,064</u>	<u>4,064</u>	8
9	SNF/PED					9
10	ICF	<u>15,621</u>	<u>12,198</u>		<u>27,819</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,621</u>	<u>12,198</u>	<u>4,064</u>	<u>31,883</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.40%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Laundry

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 4,064

Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2007 Fiscal Year: _____

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

Facility Name & ID Number Carlyle Healthcare Center # 10660 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	259,562	13,917	8,492	281,971		281,971		281,971		1
2	Food Purchase		192,071		192,071	(3,860)	188,211	(8,157)	180,054		2
3	Housekeeping	117,752	25,337		143,089		143,089		143,089		3
4	Laundry	81,368	11,942	1,047	94,357		94,357	(560)	93,797		4
5	Heat and Other Utilities			125,219	125,219		125,219		125,219		5
6	Maintenance	94,286	17,121	61,455	172,862		172,862	(546)	172,316		6
7	Other (specify):* Income Tax			6,474	6,474		6,474	(6,474)			7
8	TOTAL General Services	552,968	260,388	202,687	1,016,043	(3,860)	1,012,183	(15,737)	996,446		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,479,888	207,358	1,800	1,689,046		1,689,046	(13,490)	1,675,556		10
10a	Therapy	80,017	1,404	476,917	558,338		558,338		558,338		10a
11	Activities	96,298	9,039	24,312	129,649		129,649		129,649		11
12	Social Services	23,038		2,154	25,192		25,192		25,192		12
13	CNA Training										13
14	Program Transportation	3,548	4,363		7,911		7,911	(7,911)			14
15	Other (specify):* Bad Debts			53,581	53,581		53,581	(53,581)			15
16	TOTAL Health Care and Programs	1,682,789	222,164	562,364	2,467,317		2,467,317	(74,982)	2,392,335		16
	C. General Administration										
17	Administrative	177,009			177,009		177,009	(50,000)	127,009		17
18	Directors Fees										18
19	Professional Services			382,478	382,478		382,478	(322,752)	59,726		19
20	Dues, Fees, Subscriptions & Promotions			37,001	37,001		37,001	(29,992)	7,009		20
21	Clerical & General Office Expenses	118,426	28,236	15,031	161,693		161,693	74	161,767		21
22	Employee Benefits & Payroll Taxes			338,574	338,574	3,860	342,434	(7,134)	335,300		22
23	Inservice Training & Education			56	56		56		56		23
24	Travel and Seminar			8,468	8,468		8,468		8,468		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,294	81,294		81,294		81,294		26
27	Other (specify):* Contributions			275	275		275	(275)			27
28	TOTAL General Administration	295,435	28,236	863,177	1,186,848	3,860	1,190,708	(410,079)	780,629		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,531,192	510,788	1,628,228	4,670,208		4,670,208	(500,798)	4,169,410		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			147,495	147,495	147,495	1,541	149,036			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			54,875	54,875	54,875	(20,040)	34,835			32
33	Real Estate Taxes			39,100	39,100	39,100	574	39,674			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			828	828	828		828			35
36	Other (specify):* Sales Tax			6,036	6,036	6,036	(6,036)				36
37	TOTAL Ownership			248,334	248,334	248,334	(23,961)	224,373			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops		1,152	19,403	20,555	20,555		20,555			40
41	Coffee and Gift Shops		12,049		12,049	12,049		12,049			41
42	Provider Participation Fee			65,165	65,165	65,165		65,165			42
43	Other (specify):* penalty			129	129	129	(129)				43
44	TOTAL Special Cost Centers		13,201	84,697	97,898	97,898	(129)	97,769			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,531,192	523,989	1,961,259	5,016,440	5,016,440	(524,888)	4,491,552			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: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(6,871)	10		3
4	Non-Patient Meals	(7,484)	2		4
5	Telephone, TV & Radio in Resident Rooms	(546)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(6,619)	10		7
8	Laundry for Non-Patients	(560)	4		8
9	Non-Straightline Depreciation	1,541	30		9
10	Interest and Other Investment Income	(20,040)	32		10
11	Discounts, Allowances, Rebates & Refunds	(673)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,036)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,911)	14		16
17	Non-Care Related Fees	(54,729)	19		17
18	Fines and Penalties	(129)	43		18
19	Entertainment				19
20	Contributions	(275)	27		20
21	Owner or Key-Man Insurance	(7,134)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,581)	15		24
25	Fund Raising, Advertising and Promotional	(30,273)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,474)	7		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Pro Tx</u>	574	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (207,220)		\$	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)	(317,668)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (317,668)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (524,888)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		52

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlyle Healthcare Center

0010660

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,157)	0	0	0	0	0	0	0	0	0	0	(8,157)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(560)	0	0	0	0	0	0	0	0	0	0	(560)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(546)	0	0	0	0	0	0	0	0	0	0	(546)	6
7	Other (specify):*	(6,474)	0	0	0	0	0	0	0	0	0	0	(6,474)	7
8	TOTAL General Services	(15,737)	0	0	0	0	0	0	0	0	0	0	(15,737)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,490)	0	0	0	0	0	0	0	0	0	0	(13,490)	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	(7,911)	0	0	0	0	0	0	0	0	0	0	(7,911)	14
15	Other (specify):*	(53,581)	0	0	0	0	0	0	0	0	0	0	(53,581)	15
16	TOTAL Health Care and Programs	(74,982)	0	0	0	0	0	0	0	0	0	0	(74,982)	16
	C. General Administration													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(54,729)	(268,023)	0	0	0	0	0	0	0	0	0	(322,752)	19
20	Fees, Subscriptions & Promotions	(30,273)	281	0	0	0	0	0	0	0	0	0	(29,992)	20
21	Clerical & General Office Expenses	0	74	0	0	0	0	0	0	0	0	0	74	21
22	Employee Benefits & Payroll Taxes	(7,134)	0	0	0	0	0	0	0	0	0	0	(7,134)	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):*	(275)	0	0	0	0	0	0	0	0	0	0	(275)	27
28	TOTAL General Administration	(92,411)	(317,668)	0	(410,079)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(183,130)	(317,668)	0	(500,798)	29								

STATE OF ILLINOIS

Facility Name & ID Number Carlyle Healthcare Center

0010660

Report Period Beginning:

01/01/07 Ending:

Summary B

12/31/07

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	(20,040)	0	0	0	0	0	0	0	0	0	0	(20,040)	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):*	(6,036)	0	0	0	0	0	0	0	0	0	0	(6,036)	36
37	TOTAL Ownership	(24,535)	0	0	0	0	0	0	0	0	0	0	(24,535)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(129)	0	0	0	0	0	0	0	0	0	0	(129)	43
44	TOTAL Special Cost Centers	(129)	0	0	0	0	0	0	0	0	0	0	(129)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(207,794)	(317,668)	0	(525,462)	45								

Facility Name & ID Number Carlyle Healthcare Center

0010660

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
				WDM Health SCVs	Quincy	Management
Dorothy Messick	52	St. Vincents Home Inc	Quincy			
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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management	\$ 322,000	WDM Health Services Inc.		\$ 51,535	\$ (270,465)	1
2	V	19 Accounting		WDM Health Services Inc.		2,333	2,333	2
3	V	19 Legal		WDM Health Services Inc.		109	109	3
4	V	21 Office Supplies		WDM Health Services Inc.		74	74	4
5	V	20 Dues & Subscriptions		WDM Health Services Inc.		281	281	5
6	V							6
7	V							7
8	V							8
9	V	17 Officer Wages	100,000	ST. Vincents Home Inc.		50,000	(50,000)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 422,000			\$ 104,332	\$ * (317,668)	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: 01/01/07 Ending: 12/31/07

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 Home			100.00					322,000	19-3	9
10											10
11	WDM Health Services Inc.										11
12	Ann Reis		Clinton Manor			2	4.00				12
13								TOTAL	\$ 422,000		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: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	19	Management	Patient Days	56,711	2	\$ 91,667	\$ 91,667	31,883	\$ 51,535	1
2	19	Accounting	Patient Days	56,711	2	4,150		31,883	2,333	2
3	19	Legal	Patient Days	56,711	2	193		31,883	109	3
4	21	Office Supplies	Patient Days	56,711	2	132		31,883	74	4
5	20	Dues & subscriptions	Patient Days	56,711	2	500		31,883	281	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 96,642	\$ 91,667		\$ 54,332	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			
A. Directly Facility Related																				
Long-Term																				
1	First National Bank		X	Mortgage	\$16,200.00	11/10/09	\$ 1,952,000	\$ 1,892,221	11/10/09	7.2500	\$ 53,544	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Assurance Agency		X	Insurance finance charges		05/15/07					1,331	6								
7												7								
8												8								
9	TOTAL Facility Related				\$16,200.00		\$ 1,952,000	\$ 1,892,221			\$ 54,875	9								
B. Non-Facility Related*																				
10												10								
11				Investment Income							(20,040)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (20,040)	14								
15	TOTALS (line 9+line14)						\$ 1,952,000	\$ 1,892,221			\$ 34,835	15								

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

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Carlyle Healthcare Center

0010660 Report Period Beginning: 01/01/07

Ending: 12/31/07

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

B. Real Estate Taxes

<p>Important, 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 2006 report.		\$ 45,822	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.)		\$ 2006 46,417	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 595	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 39,079	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.		\$ *39,674	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	42,606	8
	2003	43,063	9
	2004	45,554	10
	2005	45,822	11
	2006	46,417	12
*574 Added to schedule V to reflect amount of tax for Nursing Home see attached property tax breakdown			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0010660

CONTACT PERSON REGARDING THIS REPORT Verna Germanceri

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 2006 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 2006.

(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>45,906.00</u>	\$ <u>39,163.00</u>
2. <u>08-08-18-353-004</u>	<u>Nursing Home</u>	\$ <u>511.00</u>	\$ <u>511.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>46,417.00</u>	\$ <u>39,674.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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).

Villa Catherine Village 11112 Sq Ft 6 Buildings 12 cottages

Villa Catherine Assisted Living 8334 Sq ft 12 units

Villa Catherine Supportive Living 12000Sq Ft 17 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	TOTALS	265,381		\$ 103,500	3

Facility Name & ID Number Carlyle Healthcare Center

0010660

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	44		1969	1969	\$ 30,426	\$	30	\$	\$	\$ 30,426	4
5	4		1988	1988	99,400	3,332	30	3,332		63,023	5
6	1		1977	1977	21,293	122	30	122		21,293	6
7	25		1973	1973	138,148		30			138,148	7
8	3		1993	1993	399,471	13,420	30	13,420		199,289	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	367	30	367		10,750	11
12		SPRINKLER		1974	32,694		25			32,694	12
13		BUILDING IMPROVMT		1975	14,572		20			14,572	13
14		BUILDING IMPROVMT		1970	1,588		20			1,588	14
15		BUILDING IMPROVMT		1973	3,328		20			3,328	15
16		BUILDING IMPROVMT		1974	825		20			825	16
17		PLAN OF CORRECTN		1975	21,969		20			21,969	17
18		GUARDS		1980	1,379		8			1,379	18
19		ALARM SYSTEM		1980	1,200		8			1,200	19
20		BUILDING IMPVMT GARAGE		1984	12,050		15			12,050	20
21		LAND IMPROVMTS		1987	37,715	794	20	794		37,715	21
22		BUILDING IMPVMT		1988	30,824		20	1,541	1,541	29,792	22
23		BUILDING ADTN GLASS ENCLOSER		1986	319,491	10,721	30	10,721		224,792	23
24		ROOM REMODELING		1988	16,596	556	30	556		10,522	24
25		ROOM REMODELING		1989	1,948	66	30	66		1,228	25
26		WINDOWS		1989	3,230	109	30	109		2,007	26
27		ROOF		1989	11,294	386	30	386		7,047	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		26,491	32
33		ELEVATOR		1997	83,288	4,190	20	4,190		41,738	33
34		LANDSCAPING/RAILING		1997	8,550	575	15	575		5,720	34
35		LAND IMPROVMTS		1993	51,227	3,508	15	3,508		48,954	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

0010660

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$	\$ 5,755	37
38	FLOOR CORRECTION	1999	28,360	1,425	20	1,425		12,324	38
39	HALLWAY REMODELING	1999	10,315	1,048	15	1,048		8,830	39
40	NEW ROOF CTR/BOILER	2000	19,203	1,557	15	1,557		11,809	40
41	NEW GARAGE	2001	51,030	1,707	30	1,707		11,044	41
42	LANDSCAPING	2001	20,000	1,343	15	1,343		8,700	42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,685	15	1,685		10,919	43
44	WINDOWS	2001	82,000	4,120	20	4,120		25,355	44
45	CENTER ROOF	2003	29,822	1,498	20	1,498		7,356	45
46	DINNING ROOM WINDOWS	2003	41,266	2,072	20	2,072		9,146	46
47	NEW PATIO	2003	73,579	3,696	20	3,696		17,829	47
48	SPRINKLER WALKINCOOLER/PATIO	2003	7,524	376	20	376		1,848	48
49	LOADING DOCK LIFT	2003	16,905	1,334	15	1,334		5,472	49
50	HOT WATER HTR	2004	3,285	410	8	410		1,266	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	353	15	353		1,119	51
52	TUCKPOINTING	2004	6,835	684	10	684		2,278	52
53	TRANSFORMER FOR BUILDING	2004	15,008	756	20	756		2,468	53
54	SPRINKLER MIDDLE SECTION	2004	63,606	3,181	20	3,181		9,793	54
55	SOUTH CENTER SECTION ROOF	2005	13,800	920	15	920		2,453	55
56	KITCHEN HOOD/EXHAUST SYSTEM	2005	21,763	1,088	20	1,088		2,902	56
57	FIRE SURPRESSION SYSTEM/HOOD	2005	3,114	208	15	208		554	57
58	DOUBLE DOORS TO ALHZIEMERS WING	2005	2,103	266	8	266		664	58
59	HOSPITALITY CENTER	2005	2,922	365	8	365		882	59
60	KITCHEN REMODELING	2005	57,120	2,856	20	2,856		6,188	60
61	17 TREES	2005	7,613	380	20	380		793	61
62	DISHERWASHER ROOM REMODELING	2006	4,561	212	20	212		684	62
63	FIRST FLOOR DINNING ROOM REMODEL	2006	9,488	633	15	633		1,054	63
64	WONDER GUARD	2006	27,397	3,461	15	3,461		5,191	64
65	3 CENTRAL HTG/AC UNITS	2006	26,026	1,735	15	1,735		2,169	65
66	WATER SOFTNER	2006	2,995	374	8	374		468	66
67	NEW ROOF FIRST FL&CHAPEL	2007	9,859	329	20	329		329	67
68	2ND FLOOR KITCHEN	2007	5,377	157	20	157		157	68
69	HANDRAILS	2007	8,072	90	15	90		90	69
70	TOTAL (lines 4 thru 69)		\$ 2,377,791	\$ 81,347		\$ 82,888	\$ 1,541	\$ 1,396,475	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: 01/01/07 Ending: 12/31/07

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	\$ 477,740	\$ 54,395	\$ 54,395	\$	8	\$ 240,571	71
72	Current Year Purchases	55,776	3,281	3,281		8	3,281	72
73	Fully Depreciated Assets	40,793					40,793	73
74								74
75	TOTALS	\$ 574,309	\$ 57,676	\$ 57,676	\$		\$ 284,645	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 wlift	2006	\$ 42,356	\$ 8,472	\$ 8,472	\$	5	\$ 15,531	76
77										77
78										78
79										79
80	TOTALS			\$ 42,356	\$ 8,472	\$ 8,472	\$		\$ 15,531	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,097,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,495	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,036	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,541	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,696,651	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	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	TOTAL				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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	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.

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)	
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.)

	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	4					
					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):									13
14	TOTAL			\$		\$	\$		\$	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 303,938	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	666,655		3
4	Supply Inventory (priced at <u>FIFO</u>)	8,317		4
5	Short-Term Investments	622,975		5
6	Prepaid Insurance	42,553		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)	\$ 1,644,438	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(121,387)		12
13	Land	128,950		13
14	Buildings, at Historical Cost	4,603,622		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	978,248		16
17	Accumulated Depreciation (book methods)	(2,383,049)		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>	17,572		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,223,956	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,868,394	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,101	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,530		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,394		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,892		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 308,917	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,892,221		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Income Trusts</u>	17,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,909,221	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,218,138	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,650,256	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,868,394	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,545,502	1
2	Restatements (describe):		2
3	Federal Income Tax Adj Prior Year	(2,495)	3
4	Prior Year end Adjustments	(5,538)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,537,469	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	14,892	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>	97,895	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 112,787	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)	\$ 2,650,256	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Carlyle Healthcare Center# 0010660Report Period Beginning: 01/01/07Ending: 12/31/07**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,647,971	1
2	Discounts and Allowances for all Levels	43,612	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,691,583	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	224,239	6
7	Oxygen	18,561	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 242,800	8
C. Other Operating Revenue			
9	Payments for Education	1,100	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	14,587	12
13	Barber and Beauty Care	21,292	13
14	Non-Patient Meals	7,484	14
15	Telephone, Television and Radio	546	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,201	17
18	Sale of Supplies to Non-Patients	4,418	18
19	Laboratory	5,966	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	560	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 58,154	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	20,040	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,040	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached List	18,755	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,755	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,031,332	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,016,043	31
32	Health Care	2,467,317	32
33	General Administration	1,186,848	33
B. Capital Expense			
34	Ownership	248,334	34
C. Ancillary Expense			
35	Special Cost Centers	32,733	35
36	Provider Participation Fee	65,165	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,016,440	40
41	Income before Income Taxes (line 30 minus line 40)**	14,892	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 14,892	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:

01/01/07

Ending:

12/31/07

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	2,000	2,179	\$ 54,926	\$ 25.21	1
2	Assistant Director of Nursing	1,819	2,011	47,528	23.63	2
3	Registered Nurses	10,468	11,008	218,058	19.81	3
4	Licensed Practical Nurses	22,551	23,884	415,634	17.40	4
5	CNAs & Orderlies	68,781	72,443	743,742	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,838	6,158	80,017	12.99	8
9	Activity Director	2,000	2,088	34,620	16.58	9
10	Activity Assistants	7,128	7,584	61,678	8.13	10
11	Social Service Workers	1,997	2,089	23,038	11.03	11
12	Dietician					12
13	Food Service Supervisor	1,971	2,067	24,030	11.63	13
14	Head Cook	1,973	2,269	25,393	11.19	14
15	Cook Helpers/Assistants	20,125	20,760	167,520	8.07	15
16	Dishwashers	6,091	6,624	42,619	6.43	16
17	Maintenance Workers	6,361	6,849	94,286	13.77	17
18	Housekeepers	13,965	14,838	117,752	7.94	18
19	Laundry	8,770	9,354	81,368	8.70	19
20	Administrator	2,088	2,088	77,009	36.88	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	100,000	47.89	22
23	Office Manager	2,055	2,327	33,080	14.22	23
24	Clerical	5,709	6,104	85,346	13.98	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>TRANSPORTATI</u>	458	482	3,548	7.36	33
34	TOTAL (lines 1 - 33)	194,236	205,294	\$ 2,531,192 *	\$ 12.33	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	207	\$ 8,492	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant				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	39	2,154	12-3	45
46	Other(specify)				46
47	<u>Religious</u>		24,312	11-3	47
48					48
49	TOTAL (lines 35 - 48)	390	\$ 40,358		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

Facility Name & ID Number Carlyle Healthcare Center

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? *Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,536 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? No YES _____ 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. \$ 65,165
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. \$ 3,860 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,484
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? N
Firm Name: _____ 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.