

		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: 0036723

Facility Name: St Vincent's Home

Address: 1440 North 10th Street Quincy 62301
 Number City Zip Code

County: Adams

Telephone Number: 217-224-3780 **Fax #** 217-224-3057

HFS ID Number: 37-1069446001

Date of Initial License for Current Owners: 10/01/90

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: 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 01/01/07 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) David Reis
Prersident

(Firm Name & Address) WDM Computer Services Inc.
1900 Harrison St. Quincy, Ill 62301

(Telephone) 217-228-1950 Fax # 217-222-6053

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

Facility Name & ID Number St Vincent's Home

0036723 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 10/01/07

	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		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</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>11,491</u>	<u>327</u>	<u>2,339</u>	<u>14,157</u>	8
9	SNF/PED					9
10	ICF		<u>9,944</u>		<u>9,944</u>	10
11	ICF/DD	<u>727</u>			<u>727</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,218</u>	<u>10,271</u>	<u>2,339</u>	<u>24,828</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.71%

D. How many bed-hold days during this year were paid by the Department? 0 (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 10/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 53 and days of care provided 2,339

Medicare Intermediary National Government Services

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 St Vincent's Home # 0036723 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	166,386	19,059	3,382	188,827		188,827	188,827			1
2	Food Purchase		150,640		150,640	(500)	150,140	(11,478)	138,662		2
3	Housekeeping	81,838	14,066		95,904		95,904	95,904			3
4	Laundry	60,638	11,966		72,604		72,604	72,604			4
5	Heat and Other Utilities			96,358	96,358		96,358	96,358			5
6	Maintenance	58,945	21,475	26,162	106,582		106,582	106,582			6
7	Other (specify):*										7
8	TOTAL General Services	367,807	217,206	125,902	710,915	(500)	710,415	(11,478)	698,937		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	12,000			9
10	Nursing and Medical Records	1,163,050	205,891	3,911	1,372,852		1,372,852	1,372,852			10
10a	Therapy		820	212,686	213,506		213,506	213,506			10a
11	Activities	39,032	9,802	16,680	65,514		65,514	65,514			11
12	Social Services	66,474	109	1,080	67,663		67,663	67,663			12
13	CNA Training										13
14	Program Transportation		3,175		3,175		3,175	(16)	3,159		14
15	Other (specify):* ambulance			968	968		968	968			15
16	TOTAL Health Care and Programs	1,268,556	219,797	247,325	1,735,678		1,735,678	(16)	1,735,662		16
	C. General Administration										
17	Administrative	55,516			55,516		55,516	44,000	99,516		17
18	Directors Fees										18
19	Professional Services			41,922	41,922		41,922	1,058	42,980		19
20	Dues, Fees, Subscriptions & Promotions			43,721	43,721		43,721	(23,799)	19,922		20
21	Clerical & General Office Expenses	40,334	16,748	24,384	81,466		81,466	58	81,524		21
22	Employee Benefits & Payroll Taxes			288,365	288,365	500	288,865		288,865		22
23	Inservice Training & Education			1,297	1,297	688	1,985		1,985		23
24	Travel and Seminar			5,440	5,440	(688)	4,752		4,752		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,787	62,787		62,787		62,787		26
27	Other (specify):*										27
28	TOTAL General Administration	95,850	16,748	467,916	580,514	500	581,014	21,317	602,331		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,732,213	453,751	841,143	3,027,107		3,027,107	9,823	3,036,930		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 St Vincent's Home #0036723 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			129,727	129,727		129,727		129,727		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			136,811	136,811		136,811	(2,079)	134,732		32
33	Real Estate Taxes			37,560	37,560		37,560	1,298	38,858		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Sales Tax			428	428		428	(428)			36
37	TOTAL Ownership			304,526	304,526		304,526	(1,209)	303,317		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops	2,328	615	8,446	11,389		11,389		11,389		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,203	54,203		54,203		54,203		42
43	Other (specify):* Bad Debts			46,949	46,949		46,949	(46,949)			43
44	TOTAL Special Cost Centers	2,328	615	109,598	112,541		112,541	(46,949)	65,592		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,734,541	454,366	1,255,267	3,444,174		3,444,174	(38,335)	3,405,839		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 St Vincent's Home

0036723

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				3
4	Non-Patient Meals	(4,480)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,079)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,998)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(428)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(40,975)	19		15
16	Personal Expenses (Including Transportation)	(16)	14		16
17	Non-Care Related Fees	(6,000)	17		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,949)	43		24
25	Fund Raising, Advertising and Promotional	(24,018)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Property Taxes</u>	1,298	33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (130,645)		\$	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)	92,310		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 92,310		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (38,335)		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

St Vincent's Home

ID# 0036723
 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 St Vincent's Home

0036723

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	(11,478)	0	0	0	0	0	0	0	0	0	0	(11,478)	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	TOTAL General Services	(11,478)	0	0	0	0	0	0	0	0	0	0	(11,478)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(16)	0	0	0	0	0	0	0	0	0	0	(16)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(16)	0	0	0	0	0	0	0	0	0	0	(16)	16
	C. General Administration													
17	Administrative	(6,000)	50,000	0	0	0	0	0	0	0	0	0	44,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,975)	42,033	0	0	0	0	0	0	0	0	0	1,058	19
20	Fees, Subscriptions & Promotions	(24,018)	219	0	0	0	0	0	0	0	0	0	(23,799)	20
21	Clerical & General Office Expenses	0	58	0	0	0	0	0	0	0	0	0	58	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(70,993)	92,310	0	21,317	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,487)	92,310	0	9,823	29								

STATE OF ILLINOIS

Facility Name & ID Number St Vincent's Home

0036723

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,079)	0	0	0	0	0	0	0	0	0	0	(2,079)	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):*	(428)	0	0	0	0	0	0	0	0	0	0	(428)	36
37	TOTAL Ownership	(2,507)	0	0	0	0	0	0	0	0	0	0	(2,507)	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):*	(46,949)	0	0	0	0	0	0	0	0	0	0	(46,949)	43
44	TOTAL Special Cost Centers	(46,949)	0	0	0	0	0	0	0	0	0	0	(46,949)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(131,943)	92,310	0	(39,633)	45								

Facility Name & ID Number St Vincent's Home

0036723

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
<u>Carlyle Healthcare Inc.</u>	<u>100</u>	<u>Carlyle Healthcare Inc.</u>	<u>Carlyle</u>	<u>WDM Health Scvs</u>	<u>Quincy</u>	<u>MGMT</u>
		<u>Clinton Manor</u>	<u>New Baden</u>			

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	<u>19 Management</u>	\$	<u>WDM Health Services</u>		\$ <u>40,132</u>	\$ <u>40,132</u>	1
2	V	<u>19 Accounting</u>		<u>WDM Health Services</u>		<u>1,817</u>	<u>1,817</u>	2
3	V	<u>19 Legal</u>		<u>WDM Health Services</u>		<u>84</u>	<u>84</u>	3
4	V	<u>21 Office supplies</u>		<u>WDM Health Services</u>		<u>58</u>	<u>58</u>	4
5	V	<u>20 Dues & Subscriptions</u>		<u>WDM Health Services</u>		<u>219</u>	<u>219</u>	5
6	V							6
7	V							7
8	V							8
9	V	<u>17 Officer Salary</u>		<u>Carlyle Healthcare</u>	<u>100.00%</u>	<u>50,000</u>	<u>50,000</u>	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ <u>92,310</u>	\$ * <u>92,310</u>	14

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

Facility Name & ID Number St Vincent's Home # 0036723 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	St. Vincents			20	50.00		\$	1
2	Ann Reis	Secretary	St. Vincents			19	48.00			2
3	Sue Gray	Treasurer	St. Vincents			20	50.00			3
4										4
5	Dorothy Messick	President	Carlyle HC	52.00	100,000	20	50.00	Wages	50,000	17-3
6	Ann Reis	Secretary	Carlyle HC	24.00		19	48.00			6
7	Sue Gray	Treasurer	Carlyle HC	24.00		20	50.00			7
8										8
9	Ann Reis		Clinton Manor			2	4.00			9
10										10
11	WDM Health SCVS									11
12	Carlyle Healthcare owns 100% of St. Vincents Home			100.00						12
13								TOTAL	\$ 50,000	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 St Vincent's Home

0036723

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

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, Illinois
 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	Management Fees	Patient Days	56,711	2	\$ 91,667	\$ 24,828	\$ 40,132	1
2	19	Accounting	Patient Days	56,711	2	4,150	24,828	1,817	2
3	21	Office Supplies	Patient Days	56,711	2	132	24,828	58	3
4	19	Legal	Patient Days	56,711	2	193	24,828	84	4
5	20	Dues & Subscriptions	Patient Days	56,711	2	500	24,828	219	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	\$ 42,310	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 Bankers Trust		X	Mortgage	\$20,802.77	04/23/07	\$ 3,500,000	\$ 2,644,242	04/23/2027	6.8500	\$ 133,817	1								
2	First Bankers Trust		X	Kitvhen Equipment	\$968.58	11/05/04	50,000	20,984	11/05/2009	6.0000	2,284	2								
3												3								
4												4								
5												5								
Working Capital																				
6	First Bankers Trust		X	Line of credit		05/01/06	50,000			7.7500	710	6								
7												7								
8												8								
9	TOTAL Facility Related				\$21,771.35		\$ 3,600,000	\$ 2,665,226			\$ 136,811	9								
B. Non-Facility Related*																				
10	Investment Interest										(2,079)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(2,079)	14								
15	TOTALS (line 9+line14)						\$ 3,600,000	\$ 2,665,226			\$ 134,732	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	23,159	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 38858	2
3. Under or (over) accrual (line 2 minus line 1).			\$	15,699	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	21,861	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.			\$	* 37560	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>40,714</u>	<u>8</u>			
2003	<u>33,801</u>	<u>9</u>			
2004	<u>36,882</u>	<u>10</u>			
2005	<u>37,558</u>	<u>11</u>			
2006	<u>38,858</u>	<u>12</u>			
* added 1298 to schedule V line 33 to reconcile to actual paid					
			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 St Vincent's Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0036723

CONTACT PERSON REGARDING THIS REPORT Brenda Whatley ADM

TELEPHONE 217-224-3780 FAX #: 217-224-3858

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>23-7-0068-000-00</u>	<u>Nursing Home Property</u>	\$ <u>38,858.00</u>	\$ <u>38,858.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,858.00</u>	\$ <u>38,858.00</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? YES X 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 St Vincent's Home

0036723 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,103 B. General Construction Type: Exterior Brick Frame Fire Resitive 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).

1 Community Center

10 Assisted Living Units-Casita Catherine Assisted Living

12 Duplexes or 24 Cottage units for Independednt Living

No Expenses are in schedule V as they are in 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>114,177</u>	<u>1990</u>	<u>\$ 61,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	114,177		\$ 61,500	3

Facility Name & ID Number St Vincent's Home

0036723

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	76		1990	1976	\$ 963,000	\$ 32,123	30	\$ 32,123		\$ 550,760	4
5	23		1998	1998	878,056	31,645	30	31,645		284,241	5
6											6
7											7
8											8
		Improvement Type**									
9		LAUNDRY ROOM		1999	68,109						9
10		GLASS ENCLOSER		1990	2,972	149	20	149		2,549	10
11		DINNING ROOM ADDITION		1991	86,996	4,349	20	4,349		72,498	11
12		GARAGE		1991	35,000					35,000	12
13		LAND IMPROVEMENTS		1991	13,130					13,130	13
14		CONCRETE DRVWY LOT 1		1993	10,580	716	15	716		9,984	14
15		FIREWALL		1993	1,808	91	20	91		1,353	15
16		CONCRETE DRVWYLOT 2		1997	83,961	5,638	15	5,638		57,347	16
17		NEW ROOF		1997	141,503	4,733	30	4,733		47,229	17
18		LANDSCAPING		1997	10,358	697	15	697		6,930	18
19		ROOFTOP A/C UNITS		1997	6,995					6,995	19
20		HANDRAILS		1998	11,165	751	15	751		7,408	20
21		WALKIN FREEZOR		1998	10,485					10,485	21
22		REMODELING HALLWAYS		1998	26,569	2,705	10	2,705		24,090	22
23		FIRE DAMPERS		1999	7,122	722	10	722		5,796	23
24		8 PATIENT ROOM REMODELING		1999	11,018	740	15	740		5,897	24
25		LEVEL BUILDING		2000	74,150	3,743	20	3,743		28,297	25
26		DOORS CLOSERS,NEW VENTILATION, ELECTRICAL		2000	15,450	1,039	15	1,039		7,950	26
27		RAILING		2000	2,997	382	8	382		2,774	27
28		WATER HEATER		2000	4,851	620	8	620		4,851	28
29		LAND IMPROVEMENTS		2001	4,522	304	15	304		1,917	29
30		NEW KITCHEN		2001	55,641	3,662	15	3,662		21,988	30
31		A/C COMPRESSOR		2002	5,121	649	8	649		3,467	31
32		SMOKE DECTORS		2002	2,562	324	8	324		1,670	32
33		GENERATOR		2002	4,902	621	8	621		3,143	33
34		NEW HOT/COLD WATER LINES 100/200 WINGS		2005	29,851	995	30	995		2,156	34
35		LANDSCPING/PARKING LOT LIGHTS		2006	55,446	2,517	20	2,517		2,689	35
36											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 St Vincent's Home

0036723

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,624,320	\$ 99,915		\$ 99,915	\$	\$ 1,222,594	70

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

Facility Name & ID Number St Vincent's Home # 0036723 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	\$ 230,628	\$ 27,483	\$ 27,483	\$	8	\$ 302,116	71
72	Current Year Purchases	19,630	996	996		8	996	72
73	Fully Depreciated Assets	173,149						73
74								74
75	TOTALS	\$ 423,407	\$ 28,479	\$ 28,479	\$		\$ 303,112	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 Auto	1998 Dodge Stratus	2005	\$ 4,000	\$ 1,333	\$ 1,333	\$	3	\$ 3,444	76
77	Facility Auto	1994 GMC Truck	1999	12,000				5	12,000	77
78	Facility Auto	2000 Chev Van /lift	2000	40,067				5	40,067	78
79										79
80	TOTALS			\$ 56,067	\$ 1,333	\$ 1,333	\$		\$ 55,511	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)		\$ 3,165,294	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 129,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 129,727	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,581,217	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.

Facility Name & ID Number St Vincent's Home# 0036723

Report Period Beginning:

01/01/07

Ending:

12/31/07

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):									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 St Vincent's Home# 0036723Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (135,975)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	699,233		3
4	Supply Inventory (priced at <u>FIFO</u>)	20,132		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,090		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)	\$ 613,480	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	516,577		13
14	Buildings, at Historical Cost	3,810,520		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	882,899		16
17	Accumulated Depreciation (book methods)	(2,394,174)		17
18	Deferred Charges	22,827		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)	46,125		22
23	Other(specify): <u>CIP</u>	9,291		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,894,065	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,507,545	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 41,796	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	23,584		29
30	Accrued Salaries Payable	79,992		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,676		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,273		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(12,953)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 169,368	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,644,242		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Income Trusts</u>	634,199		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,278,441	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,447,809	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 59,736	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,507,545	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 60,118	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 60,118	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(16,192)	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>Villa Catherine Dividion</u>	11,077	15
16	Other (describe) <u>Assisted Living Division</u>	4,733	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (382)	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)	\$ 59,736	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Vincent's Home# 0036723Report 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	\$ 3,246,010	1
2	Discounts and Allowances for all Levels	24,499	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,270,509	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88,836	6
7	Oxygen	6,000	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 94,836	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,299	12
13	Barber and Beauty Care	12,413	13
14	Non-Patient Meals	4,880	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,682	17
18	Sale of Supplies to Non-Patients	54	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,328	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,079	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,079	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Dietary Supplements	7,042	28
28a	See Attached	21,188	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,230	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,427,982	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	710,915	31
32	Health Care	1,735,678	32
33	General Administration	580,514	33
B. Capital Expense			
34	Ownership	304,526	34
C. Ancillary Expense			
35	Special Cost Centers	58,338	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,444,174	40
41	Income before Income Taxes (line 30 minus line 40)**	(16,192)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (16,192)	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 St Vincent's Home

0036723

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	1,968	2,088	\$ 53,344	\$ 25.55	1
2	Assistant Director of Nursing	1,844	2,088	40,582	19.44	2
3	Registered Nurses	4,681	4,884	105,263	21.55	3
4	Licensed Practical Nurses	29,170	31,077	516,872	16.63	4
5	CNAs & Orderlies	45,709	48,199	446,989	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,088	21,214	10.16	9
10	Activity Assistants	1,929	2,136	17,818	8.34	10
11	Social Service Workers	4,900	5,380	66,474	12.36	11
12	Dietician					12
13	Food Service Supervisor	1,986	2,118	30,508	14.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,740	12,509	100,283	8.02	15
16	Dishwashers	4,410	4,630	35,595	7.69	16
17	Maintenance Workers	4,594	5,034	58,945	11.71	17
18	Housekeepers	9,315	9,974	81,838	8.21	18
19	Laundry	6,692	7,269	60,638	8.34	19
20	Administrator	2,040	2,088	55,516	26.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,539	3,764	40,334	10.72	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>B&B</u>	212	245	2,328	9.50	33
34	TOTAL (lines 1 - 33)	136,676	145,571	\$ 1,734,541 *	\$ 11.92	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	144	\$ 3,382	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	8	480	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,782	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	18	1,080	11-3	44
45	Social Service Consultant	18	1,080	12-3	45
46	Other(specify)				46
47	<u>Religious</u>		15,600	11-3	47
48					48
49	TOTAL (lines 35 - 48)	284	\$ 35,404		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Brenda Whatley	ADM		\$ 55,516	Workers' Compensation Insurance	\$ 84,111	IDPH License Fee	\$ 995	
Dorothy Messick	President	52	50,000	Unemployment Compensation Insurance	32,905	Advertising: Employee Recruitment	9,485	
				FICA Taxes	130,284	Health Care Worker Background Check	2,030	
				Employee Health Insurance	37,430	(Indicate # of checks performed <u>85</u>)		
				Employee Meals	500	Patient Background Checks	101	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	23,543	
				401K Plan Expenses	3,635	Dues & Subscriptions	1,336	
						License Fees	392	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 105,516			pg 6,8	219	
(List each licensed administrator separately.)						ILL Healthcare Assoc	5,940	
B. Administrative - Other						Less: Public Relations Expense	(23,543)	
Description			Amount			Non-allowable advertising	()	
			\$			Yellow page advertising	(475)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 288,865	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,922	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Herman Bodewes	Legal		\$ 947			\$	Out-of-State Travel	\$
WDM Computer Inc.	Accounting/processing		40,975					
WDM Health Scvs	Management		42,033				In-State Travel	
Non allow	see pg 6, 8		(40,975)				See Attached list	4,752
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 42,980	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,752

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILL Healthcare 5940
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? 475
- (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? 8yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,603 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
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. \$ 500 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,880
- (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.