

FOR BHF USE					

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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

<p>I. Facility ID Number: <u>1000071</u></p> <p>Facility Name: <u>Villa Catherine Supportive Living</u></p> <p>Address: <u>1070 6th Street</u> <u>Carlyle</u> <u>62231</u> <small>Number City Zip Code</small></p> <p>County: <u>Clinton</u></p> <p>Telephone Number: (<u>618</u>) <u>594-8383</u> Fax # <u>618 594-8384</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>01/09/2007</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Dave Reis</u> Telephone Number: (<u>217</u>) <u>228-1950</u> Email Address: _____</p>	<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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Marilyn Diekamper</u> (Title) <u>Administrator</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>David Reis President</u> (Firm Name & Address) <u>WDM Computer Services Inc. 1900 Harrison Quincy, IL 62301</u> (Telephone) <u>217) 228-1950</u> Fax <u>217-223-6053</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Marilyn Diekamper</u> (Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>David Reis President</u> (Firm Name & Address) <u>WDM Computer Services Inc. 1900 Harrison Quincy, IL 62301</u> (Telephone) <u>217) 228-1950</u> Fax <u>217-223-6053</u>
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Facility Name Villa Catherine Supportive Living

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

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

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	3,110	2,114		5,224	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,110	2,114		5,224	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.96%

D. Indicate the number of paid bed-hold days the SLF had during this year 134 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(Do not include bed-hold days in Section B.)**

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

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

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2012 Fiscal Year:

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

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

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

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

Facility Name: Villa Catherine Supportive Living

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase		28,014	190	28,204	(991)	27,213	1
2	Housekeeping, Laundry and Maintenance	1,800	4,368	2,821	8,989		8,989	2
3	Heat and Other Utilities			14,765	14,765		14,765	3
4	Other (specify):							4
5	TOTAL General Services	1,800	32,382	17,776	51,958	(991)	50,967	5
B. Health Care and Programs								
6	Health Care/ Personal Care	144,417	1,008		145,425		145,425	6
7	Activities and Social Services		2,562		2,562		2,562	7
8	Other (specify): Beauty Barber			1,827	1,827		1,827	8
9	TOTAL Health Care and Programs	144,417	3,570	1,827	149,814		149,814	9
C. General Administration								
10	Administrative and Clerical	41,272	3,018	7,320	51,610		51,610	10
11	Marketing Materials, Promotions and Advertising			547	547		547	11
12	Employee Benefits and Payroll Taxes			17,540	17,540		17,540	12
13	Insurance-Property, Liability and Malpractice			11,264	11,264		11,264	13
14	Other (specify): Training			2,377	2,377		2,377	14
15	TOTAL General Administration	41,272	3,018	39,048	83,338		83,338	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	187,489	38,970	58,651	285,110	(991)	284,119	16
Capital Expenses								
D. Ownership								
17	Depreciation			54,641	54,641		54,641	17
18	Interest			47,278	47,278	(93)	47,185	18
19	Real Estate Taxes			21,015	21,015		21,015	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Transportation		950		950	(200)	750	22
23	TOTAL Ownership		950	122,934	123,884	(293)	123,591	23
24	GRAND TOTAL (Sum of lines 16 and 23)	187,489	39,920	181,585	408,994	(1,284)	407,710	24

Facility Name: Villa Catherine Supportive Living

Report Period Beginning 01/01/2012 Ending: 12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 18.81	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	1	9.37	3
4	Activity Director & Assistants	1	9.37	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1	9.37	7
8	Dishwashers			8
9	Maintenance Workers	1	15.50	9
10	Housekeepers	1	9.37	10
11	Laundry			11
12	Managers	1	23.34	12
13	Other Administrative			13
14	Clerical	1	10.00	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	8	\$ 12.50	17

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

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

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
Carlyle Healthcare Center		Carlyle	
St. Vincent's Home		Quincy	
Clinton Manor		New Baden	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ If yes, what is the value of those services? \$ _____
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Villa Catherine Supportive Living

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VIII. OWNERSHIP COSTS

A. Purchase price of land 103,500 Year land was acquired 1969

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

*Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	17		2007	2006	\$ 1,302,304	\$ 47,469	28	\$ 47,469	\$	\$ 284,593	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvements		2006	14,167	873	15	873		5,203	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,316,471	\$ 48,342		\$ 48,342	\$	\$ 289,796	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 53,061	\$ 6,299	\$ 6,299	\$	8	\$ 40,674	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 53,061	\$ 6,299	\$ 6,299	\$		\$ 40,674	20

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

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

Facility Name: Villa Catherine Supportive Living

Report Period Beginning: 01/01/2012

Ending: 2/31/2012

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

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

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

9. Rental amount for movable equipment \$ _____

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

X. INTEREST EXPENSE

	1	Name of Lender	2		3	4	6		7	8	9		
			Related**	YES			NO	Purpose of Loan					Date of Note
							Original	Balance					
		A. Directly Facility Related											
		Long-Term											
1		First National Bank		X	Mortgage	4/16/12	\$ 3,013,000	\$ 2,976,530	4/16/17	4.8500	\$ 46,968	1	
2						/ /			/ /			2	
3						/ /			/ /			3	
		Working Capital											
4						/ /			/ /			4	
5						/ /			/ /			5	
6						/ /			/ /			6	
7		TOTAL Facility Related					\$ 3,013,000	\$ 2,976,530			\$ 46,968	7	
		B. Non-Facility Related											
8						/ /			/ /			8	
9						/ /			/ /			9	
10		TOTALS (lines 7, 8 and 9)					\$ 3,013,000	\$ 2,976,530			\$ 46,968	10	

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Villa Catherine Supportive Living

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,906	\$ 14,764	1
2	Cash-Patient Deposits	(6,580)	(17,902)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,451,991	3
4	Supply Inventory (priced at)		14,942	4
5	Short-Term Investments		552,758	5
6	Prepaid Insurance		52,837	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,326	\$ 2,069,390	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		(58,006)	12
13	Land		128,950	13
14	Buildings, at Historical Cost	1,316,471	4,965,830	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	53,061	1,473,899	16
17	Accumulated Depreciation (book methods)	(289,799)	(3,410,943)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP		807,356	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,079,733	\$ 3,907,086	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,082,059	\$ 5,976,476	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 274,103	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,767	210,549	30
31	Accrued Taxes Payable		41,234	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes		(17,000)	34
	Other Current Liabilities(specify):			
35	Deferred Income		25,212	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,767	\$ 534,098	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable		2,976,530	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$ 2,976,530	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,767	\$ 3,510,628	45
46	TOTAL EQUITY	\$ 1,080,292	\$ 2,465,848	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,082,059	\$ 5,976,476	47

*(See instructions.)

Facility Name: Villa Catherine Supportive Living

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 439,106	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 439,106	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	1,085	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,313	8
9	Non-Resident Meals	991	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 4,389	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 443,495	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	51,958	19
20	Health Care/ Personal Care	149,814	20
21	General Administration	83,338	21
B. Capital Expense			
22	Ownership	123,884	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 408,994	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 34,501	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 34,501	31

Page 4 Schedule VII A

Dorothy Messick owns 46% of Carlyle Healthcare Inc

Sue Gray owns 27% Carlyle Healthcare Inc

Ann Reis owns 27% Carlyle Healthcare Inc

Ann Reis owns 25 % of Clinton Manor Living Center Inc. New Baden, IL

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

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

Carlyle Healthcare owns 100% of Catherine Kasper Village a division of Carlyle Healthcare

Carlyle Healthcare owns 100% of St. Vincents Home Inc.

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

Carlyle Healthcare owns 100% of St. Vincents Home Inc.-Catherine Kasper Village

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

Dorothy Messick owns 50% of WDM Health Service Inc. a Management Co.

Sue Gray owns 25% of WDM Health Services Inc.

Ann Reis owns 25% of WDM Health Services Inc.

No Management Fees or owner salaries are reflected on page 3 .

Dorothy Messick received a salary of \$ 100,000 allocated 50% for Carlyle Healthcare and 50% for St. Vincents Home Inc., which is reflected on their cost reports.

Carlyle Healthcare paid WDM Health Service Inc. \$ 360,000.00 in management fees for 2012 which is reflected on the Carlyle Healthcare Cost report.

Page 4 Schedule VII C

Carlyle Healthcare provides at cost a service for laundry, maint. and refuse disposal.

Carlyle Healthcare also sells at cost to Villa Catherine : food, food supplies, laundry and housekeeping supplies.

	Carlyle Healthcare Costs	Supportive Living Costs
Food Exp.	\$10,678	\$10,678
Dietary Supplies	645	645
Laundry Fee	1080	1080
Medical Supplies		

Housekeeping Supplie	999	999
Maintenance services	1800	1800
Refuse Disposal	1761	1761
Administrative Servic	2400	2400

Page 3 Line 13 Property Taxes are based on actual assessed valu of the property by the county.
(see attached copies for details)

Schedule IV Adjustments

line 1 reduced food expense by non resident meal income

line 22 reduced by transportation income

