

		FOR BHF USE			

LL2

Supportive Living Facility
2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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</u></p> <hr/> <p>Address: <u>1070 6th Street</u> <u>Carlyle</u> <u>62231</u> Number City Zip Code</p> <p>County: <u>Clinton</u></p> <p>Telephone Number: (<u>618</u>) <u>594-8383</u> Fax # <u>618</u> <u>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>-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>01/01/2018</u> to <u>12/31/2018</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) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Jamie Nast</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Supportive Living Director</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>David Reis</u> <u>President</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy IL 62301</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) <u>217-222-2222</u> Fax <u>217-222-6053</u></td> <td></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) _____	(Date) _____		(Type or Print Name) <u>Jamie Nast</u>			(Title) <u>Supportive Living Director</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>David Reis</u> <u>President</u>			(Firm Name & Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy IL 62301</u>			(Telephone) <u>217-222-2222</u> Fax <u>217-222-6053</u>	
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Facility Name Villa Catherine

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	5,475	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	17	TOTALS	17	6,205	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	2,178	2,480		4,658	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,178	2,480		4,658	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 75.07%

D. Indicate the number of paid bed-hold days the SLF had during this year 314 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: 2018 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 principal?
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 principal?
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 principal?
If no, explain.

Facility Name: Villa Catherine

Report Period Beginning:

01/01/2018

Ending: 12/31/2018

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		41,490	1,976	43,466		43,466	1
2	Housekeeping, Laundry and Maintenance	14,000	9,742	11,905	35,647		35,647	2
3	Heat and Other Utilities			17,868	17,868		17,868	3
4	Other (specify):							4
5	TOTAL General Services	14,000	51,232	31,749	96,981		96,981	5
B. Health Care and Programs								
6	Health Care/ Personal Care	173,287	903	12,660	186,850		186,850	6
7	Activities and Social Services		2,196		2,196		2,196	7
8	Other (specify): Beauty /Barber			2,108	2,108	(2,108)		8
9	TOTAL Health Care and Programs	173,287	3,099	14,768	191,154	(2,108)	189,046	9
C. General Administration								
10	Administrative and Clerical	23,696	5,426	19,635	48,757		48,757	10
11	Marketing Materials, Promotions and Advertising			4,300	4,300		4,300	11
12	Employee Benefits and Payroll Taxes			24,155	24,155		24,155	12
13	Insurance-Property, Liability and Malpractice			14,581	14,581		14,581	13
14	Other (specify):							14
15	TOTAL General Administration	23,696	5,426	62,671	91,793		91,793	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	210,983	59,757	109,188	379,928	(2,108)	377,820	16
Capital Expenses								
D. Ownership								
17	Depreciation			50,206	50,206		50,206	17
18	Interest			41,128	41,128		41,128	18
19	Real Estate Taxes			22,998	22,998		22,998	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Transportation			126	126		126	22
23	TOTAL Ownership			114,458	114,458		114,458	23
24	GRAND TOTAL (Sum of lines 16 and 23)	210,983	59,757	223,646	494,386	(2,108)	492,278	24

Facility Name: Villa Catherine

Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.26	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	1	12.55	3
4	Activity Director & Assistants	1	12.55	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	1	12.55	7
8	Dishwashers			8
9	Maintenance Workers	1	12.55	9
10	Housekeepers	1	12.55	10
11	Laundry			11
12	Managers	1	24.15	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	7	\$ 15.59	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

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		3

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. Vincents Home		Quincy	
Southern Illinois Living center		New baden	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
WDM Health Services Inc.		Quincy		Mgmt	

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

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

VIII. OWNERSHIP COSTS

A. Purchase price of land 160,000 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	\$	\$ 564,992	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Land Improvemnets	2007		14,167	873	15	873		10,441	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	\$	\$ 575,433	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	\$ 73,094 #	\$ 1,864	\$ 1,864	\$	8	\$ 56,718	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 73,094	\$ 1,864	\$ 1,864	\$		\$ 56,718	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

Report Period Beginning: 01/01/2018

Ending: 2/31/2018

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	2	3	4	6	7	8	9		
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related									
	Long-Term									
1	First National Bank		X	Mortgage	4/1/17	\$ 3,013,000	\$ 2,405,876	4/16/22	4.8500	\$ 40,896
2					/ /			/ /		** see notes
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 3,013,000	\$ 2,405,876			\$ 40,896
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 3,013,000	\$ 2,405,876			\$ 40,896

* 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

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,940	\$ (168,970)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	100,136	1,814,272	3
4	Supply Inventory (priced at)		30,331	4
5	Short-Term Investments		329,447	5
6	Prepaid Insurance		51,207	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 109,076	\$ 2,056,287	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,000	298,950	13
14	Buildings, at Historical Cost	1,316,471	7,243,771	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	73,095	2,166,862	16
17	Accumulated Depreciation (book methods)	(632,151)	(5,140,003)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 917,415	\$ 4,569,580	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,026,491	\$ 6,625,867	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 150,524	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		219,008	29
30	Accrued Salaries Payable	2,309	254,255	30
31	Accrued Taxes Payable		51,817	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,309	\$ 675,604	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	540,000	3,350,036	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)	\$ 540,000	\$ 3,350,036	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 542,309	\$ 4,025,640	45
46	TOTAL EQUITY	\$ 484,182	\$ 2,600,227	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,026,491	\$ 6,625,867	47

*(See instructions.)

Facility Name: Villa Catherine

Report Period Beginning: 01/01/2018

Ending:

12/31/2018

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 486,254	1
2	Discounts and Allowances	(476)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 485,778	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,309	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,309	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)	\$ 488,087	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	96,981	19
20	Health Care/ Personal Care	191,154	20
21	General Administration	91,793	21
B. Capital Expense			
22	Ownership	114,458	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)	\$ 494,386	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (6,299)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (6,299)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	236,810	32
33	Private Pay - Net Inpatient Revenue	248,968	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 485,778	37

Interest expense is based on a allocation of the current interest rate on the portion of the debt of the supportive living facility.

Page 4 Schedule VII A

Sue Gray c wnes50% Carlyle Healthcare Inc.

Ann Reis c wnes45% Carlyle Healthcare Inc.

Chris Reis owns 5% of 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

Sue Gray c wnes50% of WDM Health Services Inc.

Ann Reis c wnes 50%of Wdm Health Services Inc.

No owner salaries are reflected in page 3

Page 4 Schedule VII C

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

Carlyle Healrthcare sells to Villa Cat to Villa Catherine foo and ADM fees

	Carlyle Healthcare Costs	Supportive Living Costs
Laundry Fee	1080	1080
Maintenance services	14000	14000
Refuse Disposal	10825	10825
Administrative fees	6000	6000

Page 3 line 13 Property Taxes are based on actual assessed value of the property by the county. See attached copies for details.

Schedule IV adjustments

line 8 is reduced by Beauty/barber income