

FOR BHF USE					

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**Supportive Living Facility**

**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2011)**

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><b>I. Facility ID Number:</b> <u>1000071</u></p> <p><b>Facility Name:</b> <u>Villa Catherine Supportive Living</u></p> <p><b>Address:</b> <u>1070 Sixth Street</u> <u>Carlyle</u> <u>62231</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Clinton</u></p> <p><b>Telephone Number:</b> ( <u>618-</u> ) <u>594-8383</u> Fax # <u>618- 594-8384</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>01/09/2007</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Dave Reis</u> <b>Telephone Number:</b> ( <u>217</u> ) <u>228-1950</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Marilyn Diekamper</u> (Title) <u>Administrator</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) <u>David Reis</u> <u>President</u> (Firm Name &amp; Address) <u>WDM Computer Services Inc.</u> <u>1900 Harrison</u> (Telephone) <u>217 228-1950</u> Fax <u>217-222-6053</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>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Marilyn Diekamper</u> (Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>David Reis</u> <u>President</u> (Firm Name & Address) <u>WDM Computer Services Inc.</u> <u>1900 Harrison</u> (Telephone) <u>217 228-1950</u> Fax <u>217-222-6053</u>
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Facility Name: Villa Catherine Supportive Living

Report Period Beginning:

01/01/2011

Ending: 12/31/2011

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase		25,509		25,509	(1,262)	24,247	1
2	Housekeeping, Laundry and Maintenance		5,319	3,848	9,167		9,167	2
3	Heat and Other Utilities			13,596	13,596		13,596	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>		30,828	17,444	48,272	(1,262)	47,010	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	142,440	666		143,106		143,106	6
7	Activities and Social Services		2,404		2,404		2,404	7
8	Other (specify): Beauty/Barber			2,356	2,356		2,356	8
9	<b>TOTAL Health Care and Programs</b>	142,440	3,070	2,356	147,866		147,866	9
<b>C. General Administration</b>								
10	Administrative and Clerical	39,188	2,827	7,200	49,215		49,215	10
11	Marketing Materials, Promotions and Advertising			487	487		487	11
12	Employee Benefits and Payroll Taxes			15,525	15,525		15,525	12
13	Insurance-Property, Liability and Malpractice			11,083	11,083		11,083	13
14	Other (specify): Training			1,871	1,871		1,871	14
15	<b>TOTAL General Administration</b>	39,188	2,827	36,166	78,181		78,181	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	181,628	36,725	55,966	274,319	(1,262)	273,057	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			55,123	55,123		55,123	17
18	Interest			64,884	64,884		64,884	18
19	Real Estate Taxes			20,587	20,587		20,587	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Transportation		613		613	(100)	513	22
23	<b>TOTAL Ownership</b>		613	140,594	141,207	(100)	141,107	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	181,628	37,338	196,560	415,526	(1,362)	414,164	24

Facility Name: Villa Catherine Supportive Living

Report Period Beginning 01/01/2011

Ending:

12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 18.26	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	1	9.27	3
4	Activity Director & Assistants	1	9.27	4
5	Social Service Workers			5
6	Head Cook	1	9.27	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	9.27	10
11	Laundry			11
12	Managers	1	22.41	12
13	Other Administrative			13
14	Clerical	1	9.71	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>7</b>	<b>\$ 12.49</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

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:

01/01/2011

Ending:

12/31/2011

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

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	\$	\$ 237,126	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Land Improvements			2006	14,167	873	15	873		4,330	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	\$	\$ 241,456	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	\$ 6,782	\$ 6,782	\$	8	\$ 34,374	18
19	Vehicles	19,172					19,172	19
20	TOTAL (lines 18 and 19)	\$ 72,233	\$ 6,782	\$ 6,782	\$		\$ 53,546	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: 01/01/2011

Ending: 2/31/2011

**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	<b>TOTAL</b>				\$			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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		First Natiobal Bank		X	Mortgage	4/10/10	\$ 1,952,000	\$ 1,651,209	10/10/14	5.2500	\$ 64,884	1
2						/ /			/ /		* see note	2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 1,952,000	\$ 1,651,209			\$ 64,884	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 1,952,000	\$ 1,651,209			\$ 64,884	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: 01/01/2011

Ending:

12/31/2011

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 16,305	\$ 6,734	1
2	Cash-Patient Deposits	(16,250)	(44,323)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (18,000) )		1,333,679	3
4	Supply Inventory (priced : FIFO )		13,414	4
5	Short-Term Investments		633,147	5
6	Prepaid Insurance		35,953	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 55	\$ 1,978,604	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		(60,850)	12
13	Land		128,950	13
14	Buildings, at Historical Cost	1,316,471	4,808,373	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	72,233	1,259,279	16
17	Accumulated Depreciation (book methods)	(295,001)	(3,263,515)	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		88,060	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,093,703	\$ 2,960,297	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,093,758	\$ 4,938,901	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 168,763	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,438	212,290	30
31	Accrued Taxes Payable		46,684	31
32	Accrued Interest Payable		6,796	32
33	Deferred Compensation			33
34	Federal and State Income Taxes		(49,000)	34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 1,438	\$ 385,533	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable		1,908,063	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$	\$ 1,908,063	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,438	\$ 2,293,596	45
46	<b>TOTAL EQUITY</b>	\$ 1,092,320	\$ 2,645,305	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,093,758	\$ 4,938,901	47

\*(See instructions.)

Facility Name: Villa Catherine Supportive Living

Report Period Beginning: 01/01/2011

Ending:

12/31/2011

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 446,946	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 446,946</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services	2,394	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,853	8
9	Non-Resident Meals	1,262	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 6,509</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	110	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 110</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 453,565</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	48,272	19
20	Health Care/ Personal Care	147,866	20
21	General Administration	78,181	21
<b>B. Capital Expense</b>			
22	Ownership	141,207	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 415,526</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 38,039</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 38,039</b>	<b>31</b>

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

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 Serv Inc. \$ 360,000.00 in management fees for 2011 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.	\$9,690	\$9,690
Dietary Supplies	476	476
Laundry Fee	1080	1080
Medical Supplies	18	18
Housekeeping Supplie	815	815
Maintenance services	1800	1800
Refuse Disposal	968	968
Administrative Service	2400	2400

Page 3 Line 13 Property taxes are based on actual assessed value of property by the county.  
(see attached sheet)

Schedule IV Adjustments

line 1 reduced food costs for non resident meals

line 22 reduced by transportation income