

		FOR BHF USE			

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**Supportive Living Facility**

**2007  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2007)**

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.</b></p> <p>Facility Name: <u>The Manor at Craig Farms</u></p> <p>Address: <u>3030 State Street</u> <u>Chester</u> <u>62233</u>  <small>Number City Zip Code</small></p> <p>County: <u>Randolph County</u></p> <p>Telephone Number: ( <u>618</u> ) <u>826-1400</u> Fax # <u>618 826-7022</u></p> <p>Federal Employer ID Number: <u>20-3291176</u></p> <p>Date Current Owners were Certified: <u>08/16/07</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input 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>Deborah J Edwards</u> Telephone Number: ( <u>618</u> ) <u>233-1001</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input 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>08/16/07</u> to <u>12/31/07</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 border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>J Michael Greer</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Partner</u></td> <td></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West Belleville, IL 62226</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u></td> <td></td> </tr> </table> <p align="center">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>J Michael Greer</u>			(Title) <u>Partner</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u>		(Firm Name & Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West Belleville, IL 62226</u>		(Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u>	
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Facility Name: The Manor at Craig Farms

Report Period Beginning:

08/16/07

Ending:

12/31/07

## 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		27,710	35,325	63,035	(76)	62,959	1
2	Housekeeping, Laundry and Maintenance		6,795	16,040	22,835		22,835	2
3	Heat and Other Utilities			11,827	11,827	(525)	11,302	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>		34,505	63,192	97,697	(601)	97,096	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care		4,477	64,494	68,971		68,971	6
7	Activities and Social Services		4,176	11,381	15,557		15,557	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>		8,653	75,875	84,528		84,528	9
<b>C. General Administration</b>								
10	Administrative and Clerical		12,338	58,914	71,252		71,252	10
11	Marketing Materials, Promotions and Advertising		128	37,680	37,808		37,808	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			13,072	13,072		13,072	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>		12,466	109,666	122,132		122,132	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>		55,624	248,733	304,357	(601)	303,756	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			84,634	84,634	(18,851)	65,783	17
18	Interest			54,501	54,501		54,501	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			761	761		761	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			139,896	139,896	(18,851)	121,045	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>		55,624	388,629	444,253	(19,452)	424,801	24

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

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

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		\$ 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	City
<u>1</u> The Prairie's	<u>2</u> Carbondale
St. Ann's Healthcare	Chester
Clinton Manor Nursing Home	New Baden
Manor at Mason Woods	Pinckneyville

**OTHER RELATED BUSINESS ENTITIES**

Name	City	Type of Business
<u>3</u> Greer Management Services	<u>4</u> Carlyle	<u>5</u> Management Co
JMG, LLC	Carlyle	Staffing Svc

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). Attachment1

Facility Name: The Manor at Craig Farms

Report Period Beginning: 08/16/07

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VIII. OWNERSHIP COSTS

A. Purchase price of land 55,090 Year land was acquired 2007

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	40		2007	2007	\$ 4,018,051	\$ 48,704	28	\$ 48,704	\$	\$ 48,704	1
2											2
3											3
4											4
5											5
Improvement Type											
6											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)				\$ 4,018,051	\$ 48,704		\$ 48,704	\$	\$ 48,704	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	\$ 247,431	\$ 35,347	\$ 16,496	(18,851)	5	\$ 16,495	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 247,431	\$ 35,347	\$ 16,496	(18,851)		\$ 16,495	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

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**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: N/A

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 \$ 473

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			
	<b>A. Directly Facility Related Long-Term</b>									
1	Buena Vista National Bk		X	Mortgage	8/31/07	\$ 1,955,000	\$ 1,949,896	8/31/07	7.6000	\$ 50,549
2	IL Hsg Development Auth		X	Mortgage	12/31/06	1,000,000	1,000,000	11/30/27	1.0000	3,952
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 2,955,000	\$ 2,949,896			\$ 54,501
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,955,000	\$ 2,949,896			\$ 54,501

\* 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.

## STATE OF ILLINOIS

Page 7

Facility Name: The Manor at Craig Farms

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12/31/07

12/31/07

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 106,818	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	26,470		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,928		7
8	Accounts Receivable (owners or related parties)	166,157		8
9	Other(specify): <b>Reserves Receivable</b>	373,551		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 675,924	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,090		13
14	Buildings, at Historical Cost	4,018,051		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	247,431		16
17	Accumulated Depreciation (book methods)	(84,051)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,213		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(583)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 4,266,151	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,942,075	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 53,272	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Other Accrued Liabilities</b>	42,346		35
36	<b>Accrued Developers Fees</b>	394,985		36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 490,603	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,949,896		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</b> (sum of lines 38 thru 43)	\$ 2,949,896	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 3,440,499	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,501,576	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 4,942,075	\$	47

\*(See instructions.)

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12/31/07

**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	\$ 221,258	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 221,258	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	25	7
8	Barber and Beauty Care		8
9	Non-Resident Meals	76	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 101	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	5,625	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 5,625	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)		17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 226,984	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	97,697	19
20	Health Care/ Personal Care	84,528	20
21	General Administration	122,132	21
<b>B. Capital Expense</b>			
22	Ownership	139,896	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</b> (sum of lines 19 thru 27)	\$ 444,253	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (217,269)	29
30	<b>Income Taxes</b>		30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (217,269)	31

VII: RELATED ORGANIZATIONS

	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
C.	Greer Management Services, Inc.	Management Services	\$ 12,140	\$ 18,252
	JMG II, LLC	Staffing Services	\$ 143,756	\$ 141,714