

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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>1000092</u></p> <p>Facility Name: <u>The Manor at Salem Woods</u></p> <hr/> <p>Address: <u>441 S. Hotze Road</u> <u>Salem</u> <u>62881</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Marion County</u></p> <p>Telephone Number: <u>(618) 548-8910</u> Fax # <u>(618) 548-8939</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>02/08/08</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Deborah J Edwards</u> Telephone Number: <u>(618) 233-1001</u></p> <p>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 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>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>01/01/10</u> to <u>12/31/10</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>J Michael Greer</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Partner</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) <u>(618) 233-1001</u> Fax # <u>(618) 233-6009</u></td> <td style="border: none;"></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>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 & 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 Salem Woods

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase		92,391	117,679	210,070	(7,372)	202,698	1
2	Housekeeping, Laundry and Maintenance		14,366	88,530	102,896		102,896	2
3	Heat and Other Utilities			53,507	53,507	(896)	52,611	3
4	Other (specify): Waste Removal			1,766	1,766		1,766	4
5	TOTAL General Services		106,757	261,482	368,239	(8,268)	359,971	5
B. Health Care and Programs								
6	Health Care/ Personal Care		3,774	212,655	216,429		216,429	6
7	Activities and Social Services		4,986	24,597	29,583		29,583	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		8,760	237,252	246,012		246,012	9
C. General Administration								
10	Administrative and Clerical		7,827	185,211	193,038		193,038	10
11	Marketing Materials, Promotions and Advertising		2,934	15,301	18,235		18,235	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			21,435	21,435		21,435	13
14	Other (specify):							14
15	TOTAL General Administration		10,761	221,947	232,708		232,708	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		126,278	720,681	846,959	(8,268)	838,691	16
Capital Expenses								
D. Ownership								
17	Depreciation			228,577	228,577	7,522	236,099	17
18	Interest			202,986	202,986		202,986	18
19	Real Estate Taxes			(27,555)	(27,555)		(27,555)	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,695	8,695		8,695	21
22	Other (specify): See Attached Schedule			3,786	3,786	(354)	3,432	22
23	TOTAL Ownership			416,489	416,489	7,168	423,657	23
24	GRAND TOTAL (Sum of lines 16 and 23)		126,278	1,137,170	1,263,448	(1,100)	1,262,348	24

Facility Name: The Manor at Salem Woods

Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Total (lines 1 thru 16)		\$	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 <u>1</u>	City <u>2</u>
The Prairie's	Carbondale
St. Ann's Healthcare	Chester
Clinton Manor Nursing Home	New Baden
See Attached Schedule	

OTHER RELATED BUSINESS ENTITIES

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Greer Management Services	Carlyle	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).

Facility Name: The Manor at Salem Woods

Report Period Beginning:

01/01/10

Ending:

12/31/10

VIII. OWNERSHIP COSTS

A. Purchase price of land 76,840 Year land was acquired 2008

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		2008	2008	\$ 4,203,398	\$ 152,851	28	\$ 152,851	\$	\$ 445,815	1
2	10		2008	2008	687,500	25,000	28	25,000		71,875	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)				\$ 4,890,898	\$ 177,851		\$ 177,851	\$	\$ 517,690	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	\$ 290,402	\$ 50,902	\$ 58,248	7,346		\$ 169,086	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 290,402	\$ 50,902	\$ 58,248	7,346		\$ 169,086	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: The Manor at Salem Woods

Report Period Beginning: 01/01/10

Ending: 12/31/10

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	TOTAL				\$			7

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

9. Rental amount for movable equipment \$ 8,695

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

	Name of Lender	2		3	4	6		7	8	9						
		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	Marion Co Sav Bank		X	Mortgage	5/18/07	\$ 1,950,000	\$ 1,877,659	5/18/28	7.6700	\$ 144,883	1					
2	IL Hsg Develop Auth		X	Mortgage	5/18/07	1,000,000	974,299	8/1/28	1.0000	9,743	2					
3	Marion Co Sav Bank		X	Mortgage	8/15/08	734,000	692,772	9/1/28	6.8750	48,360	3					
	Working Capital															
4					/ /			/ /			4					
5					/ /			/ /			5					
6					/ /			/ /			6					
7	TOTAL Facility Related					\$ 3,684,000	\$ 3,544,730			\$ 202,986	7					
	B. Non-Facility Related															
8					/ /			/ /			8					
9					/ /			/ /			9					
10	TOTALS (lines 7, 8 and 9)					\$ 3,684,000	\$ 3,544,730			\$ 202,986	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: The Manor at Salem Woods

Report Period Beginning: 01/01/10

Ending:

12/31/10

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 702,389	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	60,705		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,900		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	53,079		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 843,073	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	76,840		13
14	Buildings, at Historical Cost	4,890,898		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	290,402		16
17	Accumulated Depreciation (book methods)	(680,532)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	63,782		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,791)		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)	\$ 4,631,599	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,474,672	\$	25

*(See instructions.)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 27,641	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	43,689		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	15,000		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	354		34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	22,222		35
36	Accrued Developers Fees	304,271		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 413,177	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	3,501,041		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)	\$ 3,501,041	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,914,218	\$	45
46	TOTAL EQUITY	\$ 1,560,454	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,474,672	\$	47

Facility Name: The Manor at Salem Woods

Report Period Beginning: 01/01/10

Ending:

12/31/10

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	\$ 1,363,054	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,363,054	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		8
9	Non-Resident Meals	7,372	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 7,372	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	4,943	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 4,943	14
D. Other Revenue (specify):			
15	Cable TV Income	896	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 896	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,376,265	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	368,239	19
20	Health Care/ Personal Care	246,012	20
21	General Administration	232,708	21
B. Capital Expense			
22	Ownership	416,489	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 1,263,448	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 112,817	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 112,817	31

VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	<u>Name</u> <u>1</u>	<u>City</u> <u>2</u>		
	Manor at Mason Woods	Pinckneyville		
	Manor at Craig Farms	Chester		

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Management Services	\$ 80,352	\$ 35,092
	JMG II, LLC	Staffing Services	\$ 480,431	\$ 467,577

**The Manor at Salem Woods
2010**

Page 3, Schedule IV, Section A - Other General Services

Line	Amount	Description
4	1,766.00	Waste Removal

Page 3, Schedule IV, Section D - Other Ownership Expenses

Line	Amount	Description
	2,459.00	Loan Cost Amortization
	973.00	Tax Credit Amortization
	<u>354.00</u>	Replacement Tax
22	3,786.00	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(7,372.00)	Non-allowable meals not directly related to SLF resident care.
3	(896.00)	Non-allowable Cable TV expense.
17	7,522.00	Depreciation S/L adjustment \$ 7,346 Depreciation PPA adjustment 176
22	<u>(354.00)</u>	Replacement Tax
	(1,100.00)	Total

**The Manor at Salem Woods
2010**

Page 6, Schedule IX - Item 10

Model	Grand Caravan
Year	2007
Make	Dodge
Rental Expense	\$6,900
Vehicle Use	Resident Transportation