

		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>1000092</u></p> <p>Facility Name: <u>The Manor at Salem Woods</u></p> <p>Address: <u>441 S. Hotze Road</u> <u>Salem</u> <u>62881</u> <small>Number City Zip Code</small></p> <p>County: <u>Marion</u></p> <p>Telephone Number: (<u>618</u>) <u>548-8910</u> Fax # (<u>618</u>) <u>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%"> <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 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> 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>01/01/12</u> to <u>12/31/12</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%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>J Michael Greer</u> (Title) <u>Partner</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (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</u>) <u>233-1001</u> Fax # (<u>618</u>) <u>233-6009</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>J Michael Greer</u> (Title) <u>Partner</u>	Paid Preparer	(Signed) _____ (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</u>) <u>233-1001</u> Fax # (<u>618</u>) <u>233-6009</u>
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Facility Name The Manor at Salem Woods

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

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	30	Single Unit Apartment	30	10,980	1
2	20	Double Unit Apartment	20	7,320	2
3		Other			3
4	50	TOTALS	50	18,300	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	4,591	2,412		7,003	5
6	Double Unit	3,332	3,632		6,964	6
7	Other					7
8	TOTALS	7,923	6,044		13,967	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 76.32%

D. Indicate the number of paid bed-hold days the SLF had during this year 221 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? YES If yes, did the facility make all of the required payments of interest and principle? YES
If no, explain. _____

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

Facility Name: The Manor at Salem Woods

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	23,603	111,138	90,047	224,787	(6,535)	218,252	1
2	Housekeeping, Laundry and Maintenance	11,694	12,350	62,964	87,008		87,008	2
3	Heat and Other Utilities			55,692	55,692	(970)	54,722	3
4	Other (specify): Waste Removal			2,415	2,415		2,415	4
5	TOTAL General Services	35,297	123,488	211,117	369,902	(7,505)	362,397	5
B. Health Care and Programs								
6	Health Care/ Personal Care	44,828	3,639	182,769	231,236		231,236	6
7	Activities and Social Services	6,343	3,268	22,103	31,713		31,713	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	51,170	6,906	204,872	262,949		262,949	9
C. General Administration								
10	Administrative and Clerical	6,646	3,820	150,797	161,262		161,262	10
11	Marketing Materials, Promotions and Advertising		3,742	7,156	10,899		10,899	11
12	Employee Benefits and Payroll Taxes			8,176	8,176		8,176	12
13	Insurance-Property, Liability and Malpractice			19,420	19,420		19,420	13
14	Other (specify):							14
15	TOTAL General Administration	6,646	7,562	185,549	199,757		199,757	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	93,113	137,956	601,538	832,608	(7,505)	825,103	16
Capital Expenses								
D. Ownership								
17	Depreciation			203,940	203,940	31,990	235,930	17
18	Interest			181,330	181,330		181,330	18
19	Real Estate Taxes			(2,922)	(2,922)		(2,922)	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			9,700	9,700		9,700	21
22	Other (specify): See Attachment 1			4,104	4,104	(672)	3,432	22
23	TOTAL Ownership			396,152	396,152	31,318	427,470	23
24	GRAND TOTAL (Sum of lines 16 and 23)	93,113	137,956	997,690	1,228,759	23,813	1,252,572	24

Facility Name: The Manor at Salem Woods

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

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 16.49	1
2	Licensed Practical Nurses	3	13.65	2
3	Certified Nurse Assistants	5	9.32	3
4	Activity Director & Assistants	1	13.21	4
5	Social Service Workers			5
6	Head Cook	1	12.30	6
7	Cook Helpers/Assistants	3	9.55	7
8	Dishwashers	1	8.62	8
9	Maintenance Workers	1	10.33	9
10	Housekeepers	1	8.54	10
11	Laundry	1	8.88	11
12	Managers	1	21.47	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19		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
The Prairie's		Carbondale	
Clinton Manor Nursing Home		New Baden	
See Attached Schedule			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
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:

Name of related entity: _____ If yes, what is the value of those services? \$ _____ YES NO

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties:

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). YES NO

Facility Name: The Manor at Salem Woods

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	\$	\$ 751,517	1
2	10		2008	2008	687,500	25,000	28	25,000		121,875	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	\$	\$ 873,392	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	\$ 26,090	\$ 58,080	31,990		\$ 273,276	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 290,402	\$ 26,090	\$ 58,080	31,990		\$ 273,276	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: 01/01/12

Ending: 12/31/12

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Greer Management Services, Inc. (Vehicle 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 \$ 9,700

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	Marion Co Sav Bank		X	Mortgage	5/18/07	\$ 1,950,000	\$ 1,831,835	5/18/28	7.6700	\$ 129,827
2	IL Hsg Develop Auth		X	Mortgage	5/18/07	1,000,000	974,299	12/31/27	1.0000	9,743
3	Marion Co Sav Bank		X	Mortgage	8/15/08	734,000	651,463	9/1/28	6.8750	41,760
	Working Capital									
4					/ /			/ /		4
5					/ /			/ /		5
6					/ /			/ /		6
7	TOTAL Facility Related					\$ 3,684,000	\$ 3,457,597			\$ 181,330
	B. Non-Facility Related									
8					/ /			/ /		8
9					/ /			/ /		9
10	TOTALS (lines 7, 8 and 9)					\$ 3,684,000	\$ 3,457,597			\$ 181,330

* 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: 01/01/12

Ending:

12/31/12

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 686,555	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	237,384		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,317		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)	\$ 980,335	\$	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)	(1,098,724)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	63,782		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(16,657)		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)	\$ 4,206,541	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,186,876	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 27,535	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,351		29
30	Accrued Salaries Payable	16,500		30
31	Accrued Taxes Payable	4,574		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes	672		34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	28,441		35
36	Accrued Developers Fees	164,271		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 292,344	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,407,245		38
39	Mortgage Payable			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)	\$ 3,407,245	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,699,589	\$	45
46	TOTAL EQUITY	\$ 1,487,287	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,186,876	\$	47

*(See instructions.)

Facility Name: The Manor at Salem Woods

Report Period Beginning: 01/01/12

Ending:

12/31/12

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	\$ 1,185,097	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,185,097	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	6,535	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 6,535	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	659	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 659	14
D. Other Revenue (specify):			
15	Cable TV Income	970	15
16	Sundry Income	98	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,068	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,193,358	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	369,902	19
20	Health Care/ Personal Care	262,949	20
21	General Administration	199,757	21
B. Capital Expense			
22	Ownership	395,480	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)	\$ 1,228,088	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (34,730)	29
30	Income Taxes	\$ 672	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (35,402)	31

**The Manor at Salem Woods
2012**

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

Line	Amount	Description
	2,459.00	Loan Cost Amortization
	973.00	Tax Credit Amortization
	<u>672.00</u>	Replacement Tax
22	4,104.00	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(6,535.00)	Non-allowable meals not directly related to SLF resident care.
3	(970.00)	Non-allowable Cable TV expense.
17	31,990.00	Depreciation S/L adjustment
22	<u>(672.00)</u>	Replacement Tax
	23,813.00	Total

**The Manor at Salem Woods
2012**

VII: RELATED ORGANIZATIONS

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

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Mgmt Srv/Payroll Srv/Vehicle Lse	\$ 73,610	\$ 71,278
	JMG II, LLC	Staffing Services	\$ 383,346	\$ 370,120

**The Manor at Salem Woods
2012**

Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2007
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle 2

Model	Escape
Year	2004
Make	Ford
Vehicle Use	Resident Transportation

Total Rental Expense \$8,000