

		FOR BHF USE			

LL2

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.

I.

Facility Name: Castle Manor

Address: 1550 Castle Manor Drve Lincoln
Number City Zip Code

County: Logan

Telephone Number: (217) 732-2310 Fax # ()

Federal Employer ID Number: _____

Date Current Owners were Certified: 2010

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 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 _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Craig Ater

(Title) Exec VP & CFO

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) _____) 33 Fax # () _____

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: 309-823-7135
Email Address: _____

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

Facility Name Castle Manor

Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	54	Single Unit Apartment	54	19,710	1
2		Double Unit Apartment			2
3		Other			3
4	54	TOTALS	54	19,710	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
5	Single Unit	7,186	11,139		18,325	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,186	11,139		18,325	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.97%

D. Indicate the number of paid bed-hold days the SLF had during this year
 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)

none

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? YES NO

Tax Year: 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? no If yes, did the facility make all of the required payments of interest and principle?

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: Castle Manor

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			
A. General Services								
1	Dietary and Food Purchase	154,653	107,610		262,263		262,263	1
2	Housekeeping, Laundry and Maintenance	58,812	19,871		78,683		78,683	2
3	Heat and Other Utilities			97,622	97,622		97,622	3
4	Other (specify):							4
5	TOTAL General Services	213,465	127,481	97,622	438,568		438,568	5
B. Health Care and Programs								
6	Health Care/ Personal Care	212,027	2,188		214,215		214,215	6
7	Activities and Social Services	24,089	6,588		30,677		30,677	7
8	Other (specify):			8,167	8,167		8,167	8
9	TOTAL Health Care and Programs	236,116	8,776	8,167	253,059		253,059	9
C. General Administration								
10	Administrative and Clerical	124,571	6,210	113,363	244,144	(315)	243,829	10
11	Marketing Materials, Promotions and Advertising			47,043	47,043		47,043	11
12	Employee Benefits and Payroll Taxes			107,420	107,420		107,420	12
13	Insurance-Property, Liability and Malpractice			22,926	22,926		22,926	13
14	Other (specify):							14
15	TOTAL General Administration	124,571	6,210	290,752	421,533	(315)	421,218	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	574,152	142,467	396,541	1,113,160	(315)	1,112,845	16
Capital Expenses								
D. Ownership								
17	Depreciation			245,052	245,052		245,052	17
18	Interest			286,799	286,799	(220)	286,579	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,240	1,240		1,240	21
22	Other (specify):							22
23	TOTAL Ownership			533,091	533,091	(220)	532,871	23
24	GRAND TOTAL (Sum of lines 16 and 23)	574,152	142,467	929,632	1,646,251	(535)	1,645,716	24

Facility Name: Castle Manor

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	\$ 25.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7	12.00	3
4	Activity Director & Assistants			4
5	Social Service Workers	1	12.00	5
6	Head Cook	1	12.00	6
7	Cook Helpers/Assistants	5	10.00	7
8	Dishwashers			8
9	Maintenance Workers	1	15.00	9
10	Housekeepers	1	10.00	10
11	Laundry			11
12	Managers	1	40.00	12
13	Other Administrative	2	20.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	20	\$	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	Heritage Operations Group LLC	\$ 63,696	1
2			2
Total		\$ 63,696	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
St. Clara's Manor		Lincoln	

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: Castle Manor

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	54				\$ 6,893,341	\$ 192,207		\$ 192,207	\$	\$ 288,310	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)				\$ 6,893,341	\$ 192,207		\$ 192,207	\$	\$ 288,310	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	\$ 510,987	\$ 52,845	\$ 52,845	\$		\$ 78,817	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 510,987	\$ 52,845	\$ 52,845	\$		\$ 78,817	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: Castle Manor

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	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	State Bank of Lincoln		x	Mortgage	/ /	\$ 5,500,000	\$ 5,415,900	/ /2031		\$ 286,799
2					/ /			/ /		
3	SCSS	x		Mortgage	/ /	3,000,000	3,000,000	/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 8,500,000	\$ 8,415,900			\$ 286,799
	B. Non-Facility Related									
8	Interest Income				/ /			/ /		-220
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 8,500,000	\$ 8,415,900			\$ 286,579

* 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: Castle Manor

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 391,844	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	178,418		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,193		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(89,489)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 500,966	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	794,907		13
14	Buildings, at Historical Cost	6,893,341		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	510,987		16
17	Accumulated Depreciation (book methods)	(367,127)		17
18	Deferred Charges	47,850		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)	\$ 7,879,958	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,380,924	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,891	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,990		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	17,331		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Deposits	1,000		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 127,212	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,415,900		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)	\$ 8,415,900	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,543,112	\$	45
46	TOTAL EQUITY	\$ (162,188)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,380,924	\$	47

*(See instructions.)

Facility Name: Castle Manor

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	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,707,558	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,707,558	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	9,163	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 9,163	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	220	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 220	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)	\$ 1,716,941	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	438,568	19
20	Health Care/ Personal Care	253,059	20
21	General Administration	421,533	21
B. Capital Expense			
22	Ownership	533,091	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)	\$ 1,646,251	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 70,690	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 70,690	31

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg . Adjustment Line #	Amount
PETTY CASH	391,844				1,009	1,009 PETTY CA 391,844
CASH IN BANK					1,100	1,100 ACCTS RI 178,418
CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBLES
ACCOUNTS RECEIVABLE	178,418				1,110	1,110 ACCTS RECEIV-M/C
MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 20,193
A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
PREPAID INSURANCE	20,193				1,310	1,310 SUPPLIES INVENTORY
OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
FOOD INVENTORY					1,409	1,409 LAND 794,907
SUPPLIES INVENTORY					1,450	1,450 FURNITU 510,987
LAND	794,907				1,460	-78,817
FURNITURE & EQUIPMENT	510,987				1,475	1,475 CODE AL 6,893,341
ACCUM DEPR-FURN & EQUIP	-78,817				1,490	1,490 ACCUM I -288,310
BUILDING & IMPROVEMENT	6,893,341				1,530	1,530 RESIDEN' 0
ACCUM DEPR-BUILDING	-288,310				1,550	1,550 LOAN FEI 47,850
RESIDENT FUNDS	0				1,551	1,551 LOAN FEES ADDED
LOAN FEES	47,850				1,850	1,850 INTERCO -89,489
REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN' -65,891
REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
INTRACOMPANY	-89,489				2,100	2,100 ACCRUEI -21,773
ACCOUNTS PAYABLE	-65,891				2,100	2,100 PR CLEARING-BENEFITS
BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
ACCRUED PAYROLL	-21,773				2,110	2,110 ACCRUEI -21,217
ACCRUED VACATION PAY	-21,217				2,120	2,120 U.C. TAXES PAYABLE
UC TAXES PAYABLE					2,125	2,125 FICA TAX 0
FICA TAX PAYABLE	0	0			2,130	2,130 FEDERAL W/H TAX PAYABLE
FIT PAYABLE					2,140	2,140 STATE W/H TAX PAYABLE
STATE W/H PAYABLE		0			2,152	2,152 WORKERS COMP ACCRUAL
EARNED INCOME CREDIT					2,225	2,225 EMPLOYEEE INSURANCE REFUND
UC FED CREDIT REDUCTION					2,230	2,230 PAYROLL SAVINGS
PAYROLL SAVINGS					2,235	2,240 UNITED FUND

