FOR BHF USE

LL2

Supportive Living Facility

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)

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 ID Number: 1000092

Facility Name: The Manor at Salem Woods

Address: 441 S Hotze Road (Number) Salem (City) 62881 (Zip Code)

County: Marion

Telephone Number: (618) 548-8910 **Fax #** 618 548-8939

Federal Employer ID Number:

Date Current Owners were Certified: 2/8/2008

Type of Ownership:

	VOLUNTARY, NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deborah J Edwards **Telephone Number:** (618 233-1001
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/15 to 12/31/15 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) J. Michael Greer
(Title) Partner

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deborah J Edwards, CPA
(Firm Name & Address) Creason-Edwards & Cimarolli, PC, 4000 N Belt West, Belleville, IL 62226
(Telephone) 618) 233-1001 Fax 618-233-6009

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 The Manor at Salem Woods Report Period Beginning: 1/1/15 Ending: 12/31/15

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	30	Single Unit Apartment	30	10,950	1
2	20	Double Unit Apartment	20	7,300	2
3		Other			3
4	50	TOTALS	50	18,250	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	5,828	3,820		9,648	5
6	Double Unit	2,584	4,072		6,656	6
7	Other					7
8	TOTALS	8,412	7,892		16,304	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.34%

D. Indicate the number of paid bed-hold days the SLF had during this year 289 **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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 2015 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: 1/1/15 Ending: 12/31/15**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	102,949	103,747	1,631	208,327	(7,017)	201,310	1
2	Housekeeping, Laundry and Maintenance	73,652	11,562	29,056	114,271		114,271	2
3	Heat and Other Utilities			63,618	63,618	(1,523)	62,095	3
4	Other (specify):			2,674	2,674		2,674	4
5	**TOTAL General Services**	176,601	115,309	96,978	388,889	(8,540)	380,349	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	231,325	1,807	3,634	236,766		236,766	6
7	Activities and Social Services	31,453	3,084	815	35,353	(815)	34,538	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	262,779	4,892	4,449	272,119	(815)	271,304	9
	C. General Administration							
10	Administrative and Clerical	66,905	3,826	412,178	482,910		482,910	10
11	Marketing Materials, Promotions and Advertising		19,417	8,895	28,312		28,312	11
12	Employee Benefits and Payroll Taxes			66,872	66,872		66,872	12
13	Insurance-Property, Liability and Malpractice			19,585	19,585		19,585	13
14	Other (specify):							14
15	**TOTAL General Administration**	66,905	23,243	507,531	597,679		597,679	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	506,285	143,444	608,958	1,258,687	(9,355)	1,249,332	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			202,262	202,262	(16,539)	185,723	17
18	Interest			170,156	170,156		170,156	18
19	Real Estate Taxes			2,388	2,388		2,388	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,035	1,035		1,035	21
22	Other (specify):			3,790	3,790	(358)	3,432	22
23	**TOTAL Ownership**			379,631	379,631	(16,897)	362,734	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	506,285	143,444	988,589	1,638,318	(26,252)	1,612,066	24

Facility Name: The Manor at Salem Woods Report Period Beginning 1/1/15 Ending: 12/31/15

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	3	15.02	2
3	Certified Nurse Assistants	7	9.81	3
4	Activity Director & Assistants	1	13.42	4
5	Social Service Workers			5
6	Head Cook	1	11.79	6
7	Cook Helpers/Assistants	2	9.69	7
8	Dishwashers	2	9.13	8
9	Maintenance Workers	1	10.68	9
10	Housekeepers	2	9.32	10
11	Laundry	1	9.65	11
12	Managers	1	22.09	12
13	Other Administrative			13
14	Clerical	1	10.68	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	23	$	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	Name	3	City	4	Type of Business	5
The Prairies		Carbondale		Greer Management Services		Carlyle		Management Co	
Clinton Manor Nursing Home		New Baden							
See attached schedule									

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 [X]
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 [X] 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: 1/1/15 Ending: 12/31/15

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	$	$ 1,210,069	1
2	10		2008	2008	687,500	25,000	28	25,000		196,875	2
3											3
4											4
5											5
	Improvement Type										
6	Alarm Control			2013	1,217	44	28	44		125	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)				$ 4,892,115	$ 177,895		$ 177,895	$	$ 1,407,069	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	$ 323,636	$ 23,041	$ 6,502	(16,539)	5	$ 299,021	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 323,636	$ 23,041	$ 6,502	(16,539)		$ 299,021	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:** 1/1/15 **Ending:** 12/31/15

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 [X] NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 [X] NO

9. Rental amount for movable equipment $ 1,035

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 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	Marion Co Savings Bank		X	Mortgage	5/17/07	$ 1,950,000	$ 1,741,684	5/18/28	7.6700	$ 134,875	1
2	IL Hsg Development Auth		X	Mortgage	5/18/07	1,000,000	1,000,000	12/31/27	1.0000	10,000	2
3	Marion Co Savings Bank		X	Mortgage	8/15/08	734,000	560,282	9/1/28	6.7850	25,281	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 3,684,000	$ 3,301,966			$ 170,156	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 3,684,000	$ 3,301,966			$ 170,156	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:** 1/1/15 **Ending:** 12/31/15

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 951,804	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	236,597		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,039		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	55,479		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,274,919	$	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	4,892,114		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	350,149		16
17	Accumulated Depreciation (book methods)	(1,712,455)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	63,782		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,954)		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)**	$ 3,643,476	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,918,395	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,857	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,164		30
31	Accrued Taxes Payable	4,118		31
32	Accrued Interest Payable	833		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	103,554		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 159,526	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,301,966		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)**	$ 3,301,966	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 3,461,492	$	45
46	**TOTAL EQUITY**	$ 1,456,903	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 4,918,395	$	47

***(See instructions.)**

Facility Name: The Manor at Salem Woods **Report Period Beginning: 1/1/15 Ending: 12/31/15**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,510,438	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,510,438	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	3,300	7
8	Barber and Beauty Care		8
9	Non-Resident Meals	7,017	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 10,317	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	615	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 615	14
	D. Other Revenue (specify):		
15	**Cable TV Income**	1,523	15
16	**See Attachment**	(1,187)	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 336	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,521,706	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	388,889	19
20	Health Care/ Personal Care	272,119	20
21	General Administration	597,679	21
	B. Capital Expense		
22	Ownership	379,631	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)**	$ 1,638,318	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (116,612)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (116,612)	31

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

Line	Amount	Description
	2,459.10	Loan Cost Amortization
	973.33	Tax Credit Amortization
	358.00	Replacement Tax
22	3,790.43	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(7,017.00)	Non-allowable meals not directly related to SLF resident care.
3	(1,523.00)	Non-allowable Cable TV expense.
7	(815.00)	Entertainment
17	(16,539.00)	Depreciation S/L adjustment
22	(358.00)	Replacement Tax
	(26,252.00)	Total

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VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	Name 1	City 2		
	Jerseyville Estates	Jerseyville		
	Manor at Craig Farms	Chester		
	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	$ 101,677	$ 111,338

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Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle2

Model	Escape
Year	2004
Make	Ford
Vehicle Use	Resident Transportation

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Page 8, Schedule XII, Income Statement

Line	Amount	Description
	(1835.00)	Prior Period Excess Accrual
	648.00	Sundry Income
16	(1,187.00)	