

		FOR BHF USE			

LL2

Supportive Living Facility

2017

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2017)

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		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>The Manor at Salem Woods</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/17</u> to <u>12/31/17</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>441 S Hotze Road</u> <u>Salem</u> <u>62881</u>																									
County: <u>Marion</u>																									
Telephone Number: (<u>618</u>) <u>548-8910</u> Fax # <u>(618) 548-8939</u>																									
Federal Employer ID Number: _____																									
Date Current Owners were Certified: <u>02/08/2008</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>J Michael Greer</u></td></tr><tr><td>(Title) <u>Partner</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u></td></tr><tr><td>(Telephone) <u>(618) 233-1001</u> Fax <u>618-233-6009</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>J Michael Greer</u>	(Title) <u>Partner</u>	(Date) _____	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) 233-1001</u> Fax <u>618-233-6009</u>												
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Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☒ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☒ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Deborah J Edwards</u> Telephone Number: <u>(618) 233-1001</u>																									
Email Address: _____																									

Facility Name The Manor at Salem Woods

Report Period Beginning: 01/01/17 Ending: 12/31/17

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	<u>30</u>	Single Unit Apartment	<u>30</u>	<u>10,950</u>	1
2	<u>20</u>	Double Unit Apartment	<u>20</u>	<u>7,300</u>	2
3		Other			3
4	50	TOTALS	50	18,250	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	<u>6,144</u>	<u>4,215</u>		<u>10,359</u>	5
6	Double Unit	<u>3,549</u>	<u>3,456</u>		<u>7,005</u>	6
7	Other					7
8	TOTALS	9,693	7,671		17,364	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.15%

D. Indicate the number of paid bed-hold days the SLF had during this year 167 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: 2017 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. _____

STATE OF ILLINOIS

Page 3

Facility Name: The Manor at Salem Woods

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	143,113	125,350	1,863	270,327	(1,969)	268,358	1
2	Housekeeping, Laundry and Maintenance	64,392	22,503	19,202	106,097		106,097	2
3	Heat and Other Utilities			72,562	72,562	(1,180)	71,382	3
4	Other (specify): Waste Removal			2,556	2,556		2,556	4
5	TOTAL General Services	207,505	147,853	96,183	451,541	(3,149)	448,392	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	286,733	4,947	7,023	298,702		298,702	6
7	Activities and Social Services	27,600	3,633	1,960	33,193	(1,960)	31,233	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	314,333	8,579	8,983	331,895	(1,960)	329,935	9
	C. General Administration							
10	Administrative and Clerical	74,585	5,301	146,065	225,951		225,951	10
11	Marketing Materials, Promotions and Advertising		24,799	8,520	33,320		33,320	11
12	Employee Benefits and Payroll Taxes			75,306	75,306		75,306	12
13	Insurance-Property, Liability and Malpractice			21,611	21,611		21,611	13
14	Other (specify):							14
15	TOTAL General Administration	74,585	30,100	251,503	356,188		356,188	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	596,422	186,533	356,669	1,139,624	(5,109)	1,134,515	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			190,399	190,399	1,132	191,531	17
18	Interest			162,877	162,877		162,877	18
19	Real Estate Taxes			54,400	54,400		54,400	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,918	3,918		3,918	21
22	Other (specify):			50,466	50,466	(47,034)	3,432	22
23	TOTAL Ownership			462,060	462,060	(45,902)	416,158	23
24	GRAND TOTAL (Sum of lines 16 and 23)	596,422	186,533	818,729	1,601,684	(51,011)	1,550,673	24

Facility Name: The Manor at Salem Woods

Report Period Beginning: 01/01/17 Ending: 12/31/17

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	17.90	2
3	Certified Nurse Assistants	7	10.19	3
4	Activity Director & Assistants	1	13.22	4
5	Social Service Workers			5
6	Head Cook	1	13.29	6
7	Cook Helpers/Assistants	4	10.69	7
8	Dishwashers	3	9.43	8
9	Maintenance Workers	1	11.26	9
10	Housekeepers	1	9.26	10
11	Laundry	1	10.14	11
12	Managers	1	25.12	12
13	Other Administrative			13
14	Clerical	1	11.80	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	25	\$	17

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 Prairies	Carbondale
Clinton Manor Nursing Home	New Baden
See attached 2 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).

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

OTHER RELATED BUSINESS ENTITIES		
Name 3	City 4	Type of Business 5
Greer Management Services	Carlyle	Management Co.

Facility Name: The Manor at Salem Woods Report Period Beginning: 01/01/17 Ending: 12/31/17

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	\$ 0	\$ 1,515,771	1
2	10		2008	2008	687,500	25,000	28	25,000		246,875	2
3											3
4											4
5											5
	Improvement Type										
6	Alarm Control			2013	1,217	44	28	44		214	6
7	Gazebo			2017	26,497	642	28	642		642	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)				\$ 4,918,612	\$ 178,537		\$ 178,537	\$ 0	\$ 1,763,502	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	\$ 328,853	\$ 6,558	\$ 7,690	1,132	5	\$ 314,054	18
19	Vehicles	26,514	5,303	5,303		5	11,931	19
20	TOTAL (lines 18 and 19)	\$ 355,367	\$ 11,861	\$ 12,993	1,132		\$ 325,985	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: 01/01/17

Ending: 12/31/17

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Greer Mangement 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 \$ -

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 Savings Bank		X	Mortgage	5/17/07	\$ 1,950,000	\$ 1,671,474	5/18/28	7.6700	\$ 129,714	1
2	IL Hsg Development Auth		X	Mortgage	5/18/07	1,000,000	1,000,000	12/31/27	1.0000	10,833	2
3	Marion Co Savings Bank		X	Mortgage	8/15/08	734,000	491,061	9/1/28	6.7850	22,329	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 3,684,000	\$ 3,162,535			\$ 162,876	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 3,684,000	\$ 3,162,535			\$ 162,876	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: 01/01/17

Ending:

12/31/17

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,239,129	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	200,773		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,274		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,000		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,464,175	\$	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	4,918,610		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	355,366		16
17	Accumulated Depreciation (book methods)	(2,094,926)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	58,982		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(33,819)		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)	\$ 3,281,053	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,745,228	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,487	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,513		30
31	Accrued Taxes Payable	58,043		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	179,033		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 298,908	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	3,162,536		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)	\$ 3,162,536	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,461,444	\$	45
46	TOTAL EQUITY	\$ 1,283,784	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,745,228	\$	47

*(See instructions.)

Facility Name: The Manor at Salem Woods

Report Period Beginning: 01/01/17

Ending:

12/31/17

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,618,064	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,618,064	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	40	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	1,969	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,009	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	2,235	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,235	14
	D. Other Revenue (specify):		
15	Cable TV Income	1,180	15
16	Prior year overstated accrual	46,314	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 47,494	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,669,801	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	451,541	19
20	Health Care/ Personal Care	331,895	20
21	General Administration	356,188	21
	B. Capital Expense		
22	Ownership	462,060	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)	\$ 1,601,684	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 68,117	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 68,117	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 788,569	32
33	Private Pay - Net Inpatient Revenue	829,495	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,618,064	37

**The Manor at Salem Woods
2017**

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

Line	Amount	Description
	44,167.00	Bad Debt
	464.00	Loan Cost Amortization
	2,968.00	Tax Credit Amortization
	<u>2,867.00</u>	Replacement Tax
22	50,466.00	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	\$ (1,969.00)	Non-allowable meals not directly related to SLF resident care
3	\$ (1,180.00)	Non-allowable Cable TV expense.
7	\$ (1,960.00)	Entertainment
17	\$ 1,132.00	Depreciation S/L adjustment
22	<u>\$(47,034.00)</u>	Bad Debt and Replacement Tax
	\$(51,011.00)	Total

The Manor at Salem Woods, L.P.
2017

VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	<u>Name</u> <u>1</u>	<u>City</u> <u>2</u>		
	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	\$115,996	\$104,673

**The Manor at Salem Woods
2017**

Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle 2

Model	Escape
Year	2004
Make	Ford
Vehicle Use	Resident Transportation

Total Rental Expense	No Payments made
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