

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2014  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2014)**

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><b>I. Facility ID Number:</b> <u>1000132</u></p> <p><b>Facility Name:</b> <u>Jerseyville Estates</u></p> <p><b>Address:</b> <u>1210 E Fairgrounds</u> <u>Jerseyville</u> <u>62052</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Jersey</u></p> <p><b>Telephone Number:</b> ( <u>618</u> ) <u>639-9700</u> <b>Fax #</b> ( <u>618</u> ) <u>639-9701</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>8/1/2011</u></p> <p><b>Type of Ownership:</b></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><b>IRS Exemption Code</b> _____</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><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Deborah J Edwards</u> <b>Telephone Number:</b> ( <u>618</u> ) <u>233-1001</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</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%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>J. Michael Greer</u> (Title) <u>Partner</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u> (Firm Name &amp; Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u> (Telephone) ( <u>618</u> ) <u>233-1001</u> <b>Fax</b> ( <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 <b>Phone #</b> (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>J. Michael Greer</u> (Title) <u>Partner</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u> (Firm Name & Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u> (Telephone) ( <u>618</u> ) <u>233-1001</u> <b>Fax</b> ( <u>618</u> ) <u>233-6009</u>
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Facility Name Jerseyville Estates

Report Period Beginning: 1/1/14 Ending: 12/31/14

**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	10,950	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 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	5,903	3,934		9,837	5
6	Double Unit	3,486	3,553		7,039	6
7	Other					7
8	TOTALS	9,389	7,487		16,876	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.)     92.47%    

**D. Indicate the number of paid bed-hold days the SLF had during this year**     310     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:     2014     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: Jerseyville Estates

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	106,738	106,247	1,846	214,831	(150)	214,681	1
2	Housekeeping, Laundry and Maintenance	62,833	15,670	21,252	99,755		99,755	2
3	Heat and Other Utilities			52,533	52,533	(2,380)	50,153	3
4	Other (specify): Waste Removal			3,248	3,248		3,248	4
5	<b>TOTAL General Services</b>	<b>169,571</b>	<b>121,917</b>	<b>78,879</b>	<b>370,367</b>	<b>(2,530)</b>	<b>367,837</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	272,976	3,157	3,376	279,509		279,509	6
7	Activities and Social Services	25,535	3,335	595	29,465	(595)	28,870	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>298,511</b>	<b>6,492</b>	<b>3,971</b>	<b>308,974</b>	<b>(595)</b>	<b>308,379</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	69,086	5,811	121,030	195,927		195,927	10
11	Marketing Materials, Promotions and Advertising		5,337	26,062	31,399		31,399	11
12	Employee Benefits and Payroll Taxes			73,332	73,332		73,332	12
13	Insurance-Property, Liability and Malpractice			16,295	16,295		16,295	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>69,086</b>	<b>11,148</b>	<b>236,719</b>	<b>316,953</b>		<b>316,953</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>537,168</b>	<b>139,557</b>	<b>319,569</b>	<b>996,294</b>	<b>(3,125)</b>	<b>993,169</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			233,886	233,886		233,886	17
18	Interest			176,658	176,658		176,658	18
19	Real Estate Taxes			21,535	21,535		21,535	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			13,106	13,106	(11,700)	1,406	21
22	Other (specify):			(12,364)	(12,364)	13,830	1,466	22
23	<b>TOTAL Ownership</b>			<b>432,821</b>	<b>432,821</b>	<b>2,130</b>	<b>434,951</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>537,168</b>	<b>139,557</b>	<b>752,390</b>	<b>1,429,115</b>	<b>(995)</b>	<b>1,428,120</b>	<b>24</b>

Facility Name: Jerseyville Estates

Report Period Beginning 1/1/14

Ending: 12/31/14

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	3	17.32	2
3	Certified Nurse Assistants	8	10.32	3
4	Activity Director & Assistants	1	12.03	4
5	Social Service Workers			5
6	Head Cook	1	15.05	6
7	Cook Helpers/Assistants	3	9.76	7
8	Dishwashers	2	8.72	8
9	Maintenance Workers	1	10.35	9
10	Housekeepers	2	8.93	10
11	Laundry	1	8.49	11
12	Managers	1	24.44	12
13	Other Administrative			13
14	Clerical	1	9.60	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>24</b>	<b>\$</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

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 Schedule			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Greer Management Services		Carlyle		Management Co	

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: Jerseyville Estates

Report Period Beginning:

1/1/14

Ending:

12/31/14

VIII. OWNERSHIP COSTS

A. Purchase price of land 193,259 Year land was acquired 2011

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	50		2011	2011	\$ 5,775,516	\$ 210,019	28	\$ 210,019	\$	\$ 717,564	1
2											2
3											3
4											4
5											5
	<b>Improvement Type</b>										
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)				\$ 5,775,516	\$ 210,019		\$ 210,019	\$	\$ 717,564	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	\$ 182,092	\$ 23,867	\$ 23,867	\$	5	\$ 79,439	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 182,092	\$ 23,867	\$ 23,867	\$		\$ 79,439	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: Jerseyville Estates

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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	<b>TOTAL</b>				\$			7

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

9. Rental amount for movable equipment \$ 13,106

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		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		IL Hsg Development Auth		X	Mortgage	4/1/12	\$ 1,000,000	\$ 1,000,000	4/1/32	1.0000	\$ 10,833	1
2		TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	2,504,579	3/1/32	6.0000	165,825	2
3		TCAP Tranche Two		X	Mortgage	7/1/12	1,580,705	1,580,705	3/1/32			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 5,280,705	\$ 5,085,284			\$ 176,658	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 5,280,705	\$ 5,085,284			\$ 176,658	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: Jerseyville Estates

Report Period Beginning: 1/1/14

Ending:

12/31/14

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,159,680	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	212,790		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,456		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,385,926	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	193,259		13
14	Buildings, at Historical Cost	5,775,516		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	182,092		16
17	Accumulated Depreciation (book methods)	(797,003)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,993		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,010)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,370,847	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,756,773	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,811	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,164		30
31	Accrued Taxes Payable	32,988		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Other Accrued Liabilities</b>	24,958		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 85,921	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,085,284		39
40	Bonds Payable			40
41	Deferred Compensation	1,425,819		41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 6,511,103	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 6,597,024	\$	45
46	<b>TOTAL EQUITY</b>	\$ 159,749	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 6,756,773	\$	47

\*(See instructions.)

Facility Name: Jerseyville Estates

Report Period Beginning: 1/1/14

Ending:

12/31/14

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,504,812	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,504,812</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	118,893	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	150	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 119,043</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	622	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 622</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Cable TV Income	2,380	15
16	Misc. Income	240	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 2,620</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,627,097</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	370,367	19
20	Health Care/ Personal Care	308,974	20
21	General Administration	316,953	21
<b>B. Capital Expense</b>			
22	Ownership	432,821	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,429,115</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 197,982</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 197,982</b>	<b>31</b>

2014

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

Line	Amount	Description
	1,466	Tax Credit Fee Amortiaation
	<u>(13,830)</u>	Bad Debt Expense
22	(12,364)	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(150)	Non-allowable meals not directly related to SLF resident care
3	(2,380)	Non-allowable Cable TV expense
7	(595)	Entertainment
21	(11,700)	Related Party Equipment Lease
22	<u>13,830</u>	Bad Debt Expense
	(995)	



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		
	Manor at Mason Woods	Pinckneyville		
	Manor at Salem Woods	Salem		

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Mgmt Svc/Payroll Svc/Vehicle Lse	\$ 105,511	\$ 110,032







**Jerseyville Estates  
2014**

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**Vehicle 1**

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

**Vehicle 2**

Model	Vue
Year	2003
Make	Saturn
Vehicle Use	Resident Transportation

Rental Expense	\$11,700
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