

		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>1000132</u></p> <p>Facility Name: <u>Jerseyville Estates</u></p> <p>Address: <u>1210 East Fairgrounds</u> <u>Jerseyville</u> <u>62052</u> <small>Number City Zip Code</small></p> <p>County: <u>Jersey</u></p> <p>Telephone Number: (<u>618</u>) <u>639-9700</u> Fax # (<u>618</u>) <u>639-9701</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>08/01/11</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%;">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>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 Jerseyville Estates

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 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	5,451	2,037		7,488	5
6	Double Unit	2,758	4,706		7,464	6
7	Other					7
8	TOTALS	8,209	6,743		14,952	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 81.70%

D. Indicate the number of paid bed-hold days the SLF had during this year 145 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: Jerseyville Estates

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	25,735	93,403	82,196	201,334	(3,119)	198,215	1
2	Housekeeping, Laundry and Maintenance	19,799	8,320	43,085	71,203		71,203	2
3	Heat and Other Utilities			58,203	58,203	(2,049)	56,154	3
4	Other (specify): Waste Removal			2,622	2,622		2,622	4
5	TOTAL General Services	45,534	101,723	186,106	333,362	(5,168)	328,194	5
B. Health Care and Programs								
6	Health Care/ Personal Care	53,463	3,142	186,544	243,150		243,150	6
7	Activities and Social Services	7,125	4,584	25,637	37,346		37,346	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	60,588	7,727	212,181	280,496		280,496	9
C. General Administration								
10	Administrative and Clerical	13,981	6,141	147,885	168,006		168,006	10
11	Marketing Materials, Promotions and Advertising		1,485		1,485		1,485	11
12	Employee Benefits and Payroll Taxes			31,405	31,405		31,405	12
13	Insurance-Property, Liability and Malpractice			15,537	15,537		15,537	13
14	Other (specify):							14
15	TOTAL General Administration	13,981	7,625	194,826	216,433		216,433	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	120,103	117,075	593,113	830,291	(5,168)	825,123	16
Capital Expenses								
D. Ownership								
17	Depreciation			233,083	233,083		233,083	17
18	Interest			102,077	102,077		102,077	18
19	Real Estate Taxes			86,625	86,625		86,625	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			8,135	8,135		8,135	21
22	Other (specify): Tax Credit Amortization			1,466	1,466		1,466	22
23	TOTAL Ownership			431,386	431,386		431,386	23
24	GRAND TOTAL (Sum of lines 16 and 23)	120,103	117,075	1,024,499	1,261,677	(5,168)	1,256,509	24

Facility Name: Jerseyville Estates

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
2	Licensed Practical Nurses	3	16.54	2
3	Certified Nurse Assistants	6	10.32	3
4	Activity Director & Assistants	1	14.84	4
5	Social Service Workers			5
6	Head Cook	1	15.42	6
7	Cook Helpers/Assistants	2	9.40	7
8	Dishwashers	2	8.57	8
9	Maintenance Workers	1	10.25	9
10	Housekeepers	4	9.05	10
11	Laundry			11
12	Managers	1	24.22	12
13	Other Administrative			13
14	Clerical	1	9.80	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	22	\$	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 Attachment 2			

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? 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:

01/01/12

Ending:

12/31/12

VIII. OWNERSHIP COSTS

A. Purchase price of land 193,259 Year land was acquired 2007

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	\$ 0	\$ 297,527	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)				\$ 5,775,516	\$ 210,019		\$ 210,019	\$ 0	\$ 297,527	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	\$ 162,615	\$ 23,064	\$ 23,064	0	7	\$ 32,717	18
19	Less Equipment Sold	(2,801)					(374)	19
20	TOTAL (lines 18 and 19)	\$ 159,814	\$ 23,064	\$ 23,064	0		\$ 32,343	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: 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 \$ 8,135

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				
A. Directly Facility Related												
Long-Term												
1		IL Hsg Development Auth		X	Mortgage	4/1/12	\$ 1,000,000	\$ 1,000,000	4/1/32	1.0000	\$ 7,802	1
2		TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	2,658,476	3/1/32	6.0000	94,275	2
3						/ /			/ /			3
Working Capital												
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 3,700,000	\$ 3,658,476			\$ 102,077	7
B. Non-Facility Related												
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 3,700,000	\$ 3,658,476			\$ 102,077	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: 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	\$ 779,070	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	406,968		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,681		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,192,719	\$	10
	B. Long-Term Assets			
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	159,814		16
17	Accumulated Depreciation (book methods)	(329,870)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,993		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,077)		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)	\$ 5,818,635	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,011,354	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 13,853	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	68,254		29
30	Accrued Salaries Payable	20,642		30
31	Accrued Taxes Payable	5,298		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Developer Fee	131,012		35
36	Other Accrued Liabilities	84,882		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 323,940	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	3,590,222		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)	\$ 3,590,222	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,914,162	\$	45
46	TOTAL EQUITY	\$ 3,097,192	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,011,354	\$	47

*(See instructions.)

Facility Name: Jerseyville Estates

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	\$ 1,249,303	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,249,303	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	3,119	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,119	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	725	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 725	14
D. Other Revenue (specify):			
15	Cable TV Income	2,049	15
16	Sale Of Fixed Asset \$374/Misc Inc \$348	722	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 2,771	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,255,918	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	333,362	19
20	Health Care/ Personal Care	280,496	20
21	General Administration	216,433	21
B. Capital Expense			
22	Ownership	431,386	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)	\$ 1,261,677	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (5,759)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (5,759)	31

**Jerseyville Estates
2012**

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(3,119.00)	Non-allowable meals not directly related to SLF resident care
3	<u>(2,049.00)</u>	Non-allowable Cable TV expense
	(5,168.00)	

**Jerseyville Estates
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	
	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	\$ 59,211	\$ 61,423
	JMG II, LLC	Staffing Services	\$ 363,572	\$ 351,963

**Jerseyville Estates
2012**

Page 6, Schedule IX - Item 10

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	\$6,600