

		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: Jerseyvile Estates

Address: 1210 E. Fairground Jerseyville 62052
 Number City Zip Code

County: Jersey

Telephone Number: (618) 639-9700 Fax # (618) 639-9701

Federal Employer ID Number: _____

Date Current Owners were Certified: 08/01/11

Type of Ownership:

<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 _____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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) <u>J Michael Greer</u>	
	(Title) <u>Partner</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(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>	

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

Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

Date of change in certified units 08/01/11

	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		Single Unit Apartment	30	4,590	1
2		Double Unit Apartment	20	3,060	2
3		Other			3
4		TOTALS	50	7,650	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	1,020	777		1,797	5
6	Double Unit	474	407		881	6
7	Other					7
8	TOTALS	1,494	1,184		2,678	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 35.01%

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

27 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: 2011 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:

01/01/11

Ending:

12/31/11

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		39,514	36,496	76,010	(825)	75,185	1
2	Housekeeping, Laundry and Maintenance		5,313	13,031	18,344		18,344	2
3	Heat and Other Utilities			14,378	14,378	(410)	13,968	3
4	Other (specify):			986	986		986	4
5	TOTAL General Services		44,827	64,891	109,718	(1,235)	108,483	5
B. Health Care and Programs								
6	Health Care/ Personal Care		819	81,029	81,848		81,848	6
7	Activities and Social Services		867	14,864	15,731		15,731	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		1,686	95,893	97,579		97,579	9
C. General Administration								
10	Administrative and Clerical		1,353	63,276	64,629		64,629	10
11	Marketing Materials, Promotions and Advertising		3,312	6,053	9,365		9,365	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			6,094	6,094		6,094	13
14	Other (specify):							14
15	TOTAL General Administration		4,665	75,423	80,088		80,088	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		51,178	236,207	287,385	(1,235)	286,150	16
Capital Expenses								
D. Ownership								
17	Depreciation			97,161	97,161		97,161	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,163	4,163		4,163	21
22	Other (specify):			91,324	91,324	(90,713)	611	22
23	TOTAL Ownership			192,648	192,648	(90,713)	101,935	23
24	GRAND TOTAL (Sum of lines 16 and 23)		51,178	428,855	480,033	(91,948)	388,085	24

Facility Name: Jerseyville Estates

Report Period Beginning: 01/01/11 Ending: 12/31/11

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			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		\$	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	
St. Ann's Healthcare		Chester	
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.	
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:

01/01/11

Ending:

12/31/11

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	\$ 87,508	28	\$ 87,508	\$	\$ 87,508	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	\$ 87,508		\$ 87,508	\$	\$ 87,508	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	\$ 9,653	\$ 9,653	\$	7	\$ 9,653	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 162,615	\$ 9,653	\$ 9,653	\$		\$ 9,653	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: 01/01/11

Ending: 12/31/11

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 \$ 4,163

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**	YES			NO	Purpose of Loan				
							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	\$ -	1
2		TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	2,700,000	3/1/32	6.0000	-	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 3,700,000	\$ 3,700,000			\$	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 3,700,000	\$ 3,700,000			\$	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: 01/01/11

Ending:

12/31/11

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 877,648	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -)	81,141		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 958,789	\$	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	5,805,162		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	162,615		16
17	Accumulated Depreciation (book methods)	(97,161)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	112,706		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(91,324)		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)	\$ 6,085,257	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,044,046	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 14,633	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	131,645		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			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	24,451		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 301,741	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	3,639,355		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)	\$ 3,639,355	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,941,096	\$	45
46	TOTAL EQUITY	\$ 3,102,950	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,044,046	\$	47

*(See instructions.)

Facility Name: Jerseyville Estates

Report Period Beginning: 01/01/11

Ending:

12/31/11

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	\$ 211,661	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 211,661	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	825	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 825	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	385	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 385	14
D. Other Revenue (specify):			
15	Cable TV Income	410	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 410	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 213,281	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	109,718	19
20	Health Care/ Personal Care	97,579	20
21	General Administration	80,088	21
B. Capital Expense			
22	Ownership	192,648	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)	\$ 480,033	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (266,752)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (266,752)	31

**Jerseyville Estates
2011**

Page 3, Schedule IV, Section A - Other General Services

Line	Amount	Description
4	986.00	Waste Removal

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

Line	Amount	Description
	90,713.00	Start-up Marketing Costs
	<u>611.00</u>	Tax Credit Amortization
22	91,324.00	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(825.00)	Non-allowable meals not directly related to SLF resident care
3	(410.00)	Non-allowable Cable TV expense
17	<u>(90,713.00)</u>	Start-up Marketing Costs
	(91,948.00)	

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.	Management Services	\$ 10,000	\$ 26,585
	JMG II, LLC	Staffing Services	\$ 167,326	\$ 158,760

**Jerseyville Estates
2011**

Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Rental Expense	\$3,000
Vehicle Use	Resident Transportation