FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047597

Facility Name: Jerseyville Manor

Address: 1251 North State St (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6441 **Fax #** (618) 498-9025

HFS ID Number:

Date of Initial License for Current Owners: 09/28/05

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550
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 10/1/12 to 9/30/13 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) Matt Hails
(Title) LTC CEO

Paid Preparer

(Signed) See Preparation Report (Date)
(Print Name and Title) McGladrey LLP, 117 E. Main St., Suite 210
(Firm Name & Address) P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,993	13,647	8,349	43,989	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,993	13,647	8,349	43,989	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.32%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/28/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 160 and days of care provided 6,604

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/13 Fiscal Year: 9/30/13

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	267,727	23,048	5,884	296,659		296,659		296,659			1
2	Food Purchase		357,991		357,991		357,991	(1,130)	356,861			2
3	Housekeeping	163,011	52,131		215,142		215,142		215,142			3
4	Laundry	63,093	34,691		97,784		97,784		97,784			4
5	Heat and Other Utilities			185,694	185,694		185,694		185,694			5
6	Maintenance	62,258	35,288	64,239	161,785		161,785		161,785			6
7	Other (specify):*											7
8	**TOTAL General Services**	556,089	503,149	255,817	1,315,055		1,315,055	(1,130)	1,313,925			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,318,168	386,753	9,807	2,714,728		2,714,728		2,714,728			10
10a	Therapy			911,125	911,125		911,125		911,125			10a
11	Activities	87,886	2,108		89,994		89,994		89,994			11
12	Social Services	47,108			47,108		47,108		47,108			12
13	CNA Training											13
14	Program Transportation			680	680	7,990	8,670		8,670			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,453,162	388,861	936,012	3,778,035	7,990	3,786,025		3,786,025			16
	C. General Administration											
17	Administrative	133,602			133,602		133,602		133,602			17
18	Directors Fees							3,732	3,732			18
19	Professional Services			340,475	340,475		340,475	3,734	344,209			19
20	Dues, Fees, Subscriptions & Promotions			92,119	92,119		92,119	(80,188)	11,931			20
21	Clerical & General Office Expenses	71,078	33,330	48,072	152,480		152,480	210	152,690			21
22	Employee Benefits & Payroll Taxes			565,308	565,308		565,308		565,308			22
23	Inservice Training & Education			4,180	4,180		4,180		4,180			23
24	Travel and Seminar			3,047	3,047		3,047		3,047			24
25	Other Admin. Staff Transportation			15,980	15,980	(7,990)	7,990		7,990			25
26	Insurance-Prop.Liab.Malpractice			76,255	76,255		76,255	37,585	113,840			26
27	Other (specify):* See Att Sch V	50,746		58,127	108,873		108,873	(108,873)				27
28	**TOTAL General Administration**	255,426	33,330	1,203,563	1,492,319	(7,990)	1,484,329	(143,800)	1,340,529			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,264,677	925,340	2,395,392	6,585,409		6,585,409	(144,930)	6,440,479			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jerseyville Manor #0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,751	104,751		104,751	418,212	522,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							457,456	457,456			32
33	Real Estate Taxes			864	864		864	126,240	127,104			33
34	Rent-Facility & Grounds			836,544	836,544		836,544	(836,544)				34
35	Rent-Equipment & Vehicles			6,801	6,801		6,801		6,801			35
36	Other (specify):* See Att Sch IV											36
37	TOTAL Ownership			948,960	948,960		948,960	165,364	1,114,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			35,705	35,705		35,705		35,705			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			314,527	314,527		314,527		314,527			42
43	Other (specify):* Outpatient Care			1,297	1,297		1,297		1,297			43
44	TOTAL Special Cost Centers			351,529	351,529		351,529		351,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,264,677	925,340	3,695,881	7,885,898		7,885,898	20,434	7,906,332			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,130)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(33,175)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		V-21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,477)	V-27		24
25	Fund Raising, Advertising and Promotional	(80,191)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VI	(56,768)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (226,741)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	232,783		34
35	Other- Attach Schedule **See Att Sch III**	14,392		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 247,175		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,434		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Jerseyville Manor

ID# 0047597

Report Period Beginning: 10/1/12

Ending: 9/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	232,783	0	0	0	0	0	0	0	0	0	232,783	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	232,783	0	0	0	0	0	0	0	0	0	232,783	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	232,783	0	0	0	0	0	0	0	0	0	232,783	45

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 836,544	Jerseyville North State, LLC	N/A	$ 1,069,327	$ 232,783	1
2	V								2
3	V				See Att Schedule IV and Preparation Report				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 836,544			$ 1,069,327	$ * 232,783	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								$ 3,732	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,732		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Unlimited Development, Inc.
Street Address: 285 S Farnham
City / State / Zip Code: Galesburg, IL 61401
Phone Number: (309) 343-1550
Fax Number: (309) 343-2857

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		See Att Sch II & III							14,392	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 14,392	25

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. Of Illinois		X	Facility purchase	$17,694.29	5/1/2012	4,173,100	4,091,184	03/01/2046	3.5500	146,315	2
3												3
4	Community Living											4
5	Options, Inc.	X		Wing addition		8/1/2009	5,738,601	5,738,601	07/01/2039	6.0000	344,316	5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income		X								(33,175)	7
8												8
9	TOTAL Facility Related				$17,694.29		$ 9,911,701	$ 9,829,785			$ 457,456	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,911,701	$ 9,829,785			$ 457,456	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 22,350 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 88,820	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 123,322	2
3. Under or (over) accrual (line 2 minus line 1).		$ 34,502	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 92,602	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 127,104	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	53,137	8
	2009	111,236	9
	2010	113,784	10
	2011	116,445	11
	2012	123,322	12

This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained. Amount accrued includes the taxes for 9 months based on fiscal year end.

Estimate is based on prior year tax bill. Taxes paid during year represents the entire 2012 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Manor COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0047597

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-127-014-00	S17 T8 R11 UNPLATTED	$ 122,120.34	$ 122,120.34
2.		PARCELS PT SE 1/4 (TRACT	$	$
3.		1 - SURVEY IN PLAT CAB 1/54B)	$	$
4.	04-127-015-00	S17 T8 R11 UNPLATTED	$ 691.04	$ 691.04
5.		PARCELS PT SE 1/4 (PT TRACT	$	$
6.		2 PLAT CAB 1/54B)	$	$
7.	04-127-014-50	S17 T8 R11 TRACT IN SE1/4	$ 337.88	$ 337.88
8.		(PT TRACT 2 SURVEY PC1/54B)	$	$
9.	04-017-009-00	S17 T8 R11 TRACT IN SE1/4	$ 173.30	$ 173.30
10.		SE 1/4 9-04 85K, 10-00 75K	$	$
		TOTALS	$ 123,322.56	$ 123,322.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,306 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	3.5 Acres	2005	$ 160,000	1
2	Facility Addition	.88 Acres	2008	14,025	2
3	TOTALS	#VALUE!		$ 174,025	3

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	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	
4	92		2005		$ 4,578,867	$ 114,472	40	$ 114,472	$	$ 925,311	4
5	68		2008		4,926,175	197,047	25	197,047		985,235	5
6											6
7											7
8											8
	Improvement Type**										
9	Attic Insulation			2005	5,952	396	15	396		3,174	9
10	Parking Lot Lighting			2006	5,355	357	15	357		2,678	10
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop□□			2008	13,072	2,103	5-15 yrs	2,103		11,450	11
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwlks			2008	398,166	42,476	5-20 yrs	42,476		215,219	12
13	Landscaping, Fence			2008	47,677	4,487	10-15 yrs	4,487		22,430	13
14	Electric Install, Recliner Wheelchairs, Baskets			2008	37,076	2,852	13	2,852		14,022	14
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over			2008	15,149	1,515	10	1,515		7,322	15
16	Roof			2008	116,316	11,632	10	11,632		57,189	16
17	Paint & Wallpaper, Paint & Wallpaper, Fence			2008	16,441	3,089	5-8 yrs	3,089		15,389	17
18	Wndw Decs, Duct work, Veranda, outsde lights, Jrsyvile Parking Lot			2009	265,075	35,299	5-15 yrs	35,299		153,149	18
19	Water heater			2010	4,760	476	10	476		1,428	19
20	Generator			2011	3,825	765	5	765		1,720	20
21	Water heater			2011	4,407	440	10	440		918	21
22	Lobby Remodel (Contracted Total)			2011	31,490	2,624	12	2,624		7,872	22
23	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Pain			2012	68,090	5,201	12	5,201		5,201	23
24	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Gra			2012	59,732	4,563	12	4,563		4,563	24
25	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall			2012	29,696	2,268	12	2,268		2,268	25
26	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Ba			2012	30,269	2,312	12	2,312		2,312	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,657,590	$ 434,374		$ 434,374	$	$ 2,438,850	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 846,780	$ 88,003	$ 88,003	$	3-15 yrs	$ 528,407	71
72	Current Year Purchases	3,012	586	586		3 yrs	586	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 849,792	$ 88,589	$ 88,589	$		$ 528,993	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2003 GMC G3500 Van	2006	$ 29,848	$	$	$	4 yrs	$ 29,848	76
77										77
78										78
79										79
80	TOTALS			$ 29,848	$	$	$		$ 29,848	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,711,255	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 522,963	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 522,963	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,997,691	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2005 Ford E350 - 2005	$ 47,110	$	$ 47,110	86
87	2006 Toyota Corolla - 2006	15,288		15,288	87
88					88
89					89
90					90
91	TOTALS	$ 62,398	$	$ 62,398	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Jerseyville North State, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$ N/A
13.	/2015	$ N/A
14.	/2016	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,801 Description: See Attached Schedule XII
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/13 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 134,776	$ 829,266	1
2	Cash-Patient Deposits	15,425	15,425	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,720)	1,408,920	1,408,920	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,099	127,575	6
7	Other Prepaid Expenses	1,677	1,677	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	4,854,372	4,878,552	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,517,269	$ 7,261,415	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		174,025	13
14	Buildings, at Historical Cost		9,505,042	14
15	Leasehold Improvements, at Historical Cost	759,514	1,152,548	15
16	Equipment, at Historical Cost	286,512	942,038	16
17	Accumulated Depreciation (book methods)	(543,252)	(3,060,089)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement Reserve		302,255	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 502,774	$ 9,015,819	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,020,043	$ 16,277,234	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 132,040	$ 132,040	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,425	15,425	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,802	82,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	121,604	121,604	31
32	Accrued Real Estate Taxes(Sch.IX-B)		92,602	32
33	Accrued Interest Payable		700,735	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		321,822	36
37	Current portion of long term payable		68,197	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 351,871	$ 1,535,227	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,738,601	39
40	Mortgage Payable		4,022,987	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	33,000	33,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 33,000	$ 9,794,588	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 384,871	$ 11,329,815	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,635,172	$ 4,947,419	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,020,043	$ 16,277,234	48

*(See instructions.)

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,693,673	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,693,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	941,499	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 941,499	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,635,172	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,325,889	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,325,889	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	444,493	6
7	Oxygen	461	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 444,954	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,259	12
13	Barber and Beauty Care	7,663	13
14	Non-Patient Meals	1,130	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	70	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 10,320	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***	33,175	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,225	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schdule X	13,009	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,009	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,827,397	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,315,055	31
32	Health Care	3,778,035	32
33	General Administration	1,492,319	33
	B. Capital Expense		
34	Ownership	948,960	34
	C. Ancillary Expense		
35	Special Cost Centers	37,002	35
36	Provider Participation Fee	314,527	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,885,898	40
41	**Income before Income Taxes (line 30 minus line 40)****	941,499	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 941,499	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,669,592	44
45	Private Pay - Net Inpatient Revenue	2,157,755	45
46	Medicare - Net Inpatient Revenue	3,288,714	46
47	Other-(specify)		47
48	Other-(specify) See Att Schedule XI	209,828	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,325,889	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,934	2,080	$ 73,243	$ 35.21	1
2	Assistant Director of Nursing	1,744	1,876	43,346	23.11	2
3	Registered Nurses	20,248	21,772	463,967	21.31	3
4	Licensed Practical Nurses	17,737	19,072	328,793	17.24	4
5	CNAs & Orderlies	115,583	124,283	1,292,538	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,260	8,882	87,886	9.89	10
11	Social Service Workers	2,964	3,187	47,108	14.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,407	28,395	267,727	9.43	15
16	Dishwashers					16
17	Maintenance Workers	5,022	5,400	62,258	11.53	17
18	Housekeepers	16,677	17,932	163,011	9.09	18
19	Laundry	6,744	7,252	63,093	8.70	19
20	Administrator	1,934	2,080	94,924	45.64	20
21	Assistant Administrator	1,937	2,083	38,678	18.57	21
22	Other Administrative	1,906	2,050	50,746	24.75	22
23	Office Manager					23
24	Clerical	4,933	5,304	71,078	13.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,656	1,780	21,291	11.96	31
32	Other Health Care(specify)	4,786	5,146	94,990	18.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	240,472	258,574	$ 3,264,677 *	$ 12.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 5,884	1-3	35
36	Medical Director	***	14,400	9-3	36
37	Medical Records Consultant	***	1,291	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	8,516	10-3	39
40	Physical Therapy Consultant	***	401,334	10a-3	40
41	Occupational Therapy Consultant	***	387,510	10a-3	41
42	Respiratory Therapy Consultant	***	3,783	10a-3	42
43	Speech Therapy Consultant	***	118,498	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***		10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 941,216		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Bainter	Administrator	None	$ 94,924
Mary Mosby	Asst Admin	None	38,678
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,602

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc	Administrative Services	$ 171,600
McGladrey LLP	Accounting Services	23,296
LTC Support Services, LLC	Support Services	140,250
Norbert J. Goetten	Collection Services	3,372
Polsinelli PC	Legal Services	1,957
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 340,475

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 116,678
Unemployment Compensation Insurance	18,126
FICA Taxes	245,024
Employee Health Insurance	164,895
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	17,064
Other Employee Benefits	3,521
TOTAL (agree to Schedule V, line 22, col.8)	$ 565,308

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	422
Health Care Worker Background Check	
(Indicate # of checks performed 22)	1,050
Patient Background Checks 145	1,450
Advertising - Promotion	80,191
Subscriptions	995
IHCA Dues	6,182
Other Licenses & Fees	1,829
Indirect Costs - See Att Sch III	3
Less: Public Relations Expense	( )
Non-allowable advertising	(80,191)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,931

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	
travel voucher)	0
Seminar Expense	3,047
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,047

**See instructions.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/12 Ending: 9/30/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Page 21 section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes - IHCA dues** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,258** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **314,527**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,130**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.