

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

<p>I. IDPH License ID Number: <u>0047597</u></p> <p>Facility Name: <u>Jerseyville Manor</u></p> <p>Address: <u>1251 North State St</u> <u>Jerseyville</u> <u>62052</u> Number City Zip Code</p> <p>County: <u>Jersey</u></p> <p>Telephone Number: <u>(618) 498-6441</u> Fax # <u>(618) 498-9025</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>09/28/05</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) (3)</u></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>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) (3)</u>	<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>10/1/13</u> to <u>9/30/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Matt Hails</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>LTC CEO</u></td> </tr> <tr> <td rowspan="4" style="width: 20%;">Paid Preparer</td> <td>(Signed) <u>See Preparation Report</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u></td> </tr> <tr> <td>(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Matt Hails</u> (Date) _____		(Title) <u>LTC CEO</u>	Paid Preparer	(Signed) <u>See Preparation Report</u>	(Date) _____	(Print Name and Title) <u>McGladrey LLP</u> <u>117 E. Main St., Suite 210</u>	(Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u>		(Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>	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	
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Facility Name & ID Number Jerseyville Manor

0047597 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	25,066	12,878	8,519	46,463	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,066	12,878	8,519	46,463	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.56%

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

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

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 Date 9/28/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 160 and days of care provided 7,157

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 9/30/14 Fiscal Year: 9/30/14

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

Facility Name & ID Number

Jerseyville Manor

0047597

Report Period Beginning:

10/1/13

Ending:

9/30/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	284,794	25,697	8,975	319,466		319,466		319,466		1
2	Food Purchase		402,057		402,057		402,057	(1,321)	400,736		2
3	Housekeeping	184,466	46,401	55	230,922		230,922		230,922		3
4	Laundry	55,941	40,656		96,597		96,597		96,597		4
5	Heat and Other Utilities			181,151	181,151		181,151		181,151		5
6	Maintenance	83,553	47,803	62,875	194,231		194,231		194,231		6
7	Other (specify):*										7
8	TOTAL General Services	608,754	562,614	253,056	1,424,424		1,424,424	(1,321)	1,423,103		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,449,672	383,038	10,585	2,843,295		2,843,295		2,843,295		10
10a	Therapy			1,059,605	1,059,605		1,059,605		1,059,605		10a
11	Activities	88,675	3,345		92,020		92,020		92,020		11
12	Social Services	57,836			57,836		57,836		57,836		12
13	CNA Training			3,016	3,016		3,016		3,016		13
14	Program Transportation					5,694	5,694		5,694		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,596,183	386,383	1,087,606	4,070,172	5,694	4,075,866		4,075,866		16
	C. General Administration										
17	Administrative	149,967			149,967		149,967		149,967		17
18	Directors Fees							3,773	3,773		18
19	Professional Services			338,405	338,405		338,405	6,178	344,583		19
20	Dues, Fees, Subscriptions & Promotions			88,454	88,454		88,454	(74,160)	14,294		20
21	Clerical & General Office Expenses	76,087	42,768	53,862	172,717		172,717	2	172,719		21
22	Employee Benefits & Payroll Taxes			594,389	594,389		594,389		594,389		22
23	Inservice Training & Education			3,507	3,507		3,507		3,507		23
24	Travel and Seminar			985	985		985		985		24
25	Other Admin. Staff Transportation			11,387	11,387	(5,694)	5,693		5,693		25
26	Insurance-Prop.Liab.Malpractice			90,439	90,439		90,439	37,142	127,581		26
27	Other (specify):* See Att Sch V	51,993		(15,149)	36,844		36,844	(36,844)			27
28	TOTAL General Administration	278,047	42,768	1,166,279	1,487,094	(5,694)	1,481,400	(63,909)	1,417,491		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,482,984	991,765	2,506,941	6,981,690		6,981,690	(65,230)	6,916,460		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:

10/1/13

Ending:

9/30/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			96,573	96,573		96,573	418,229	514,802			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							459,461	459,461			32
33	Real Estate Taxes			903	903		903	127,680	128,583			33
34	Rent-Facility & Grounds			836,544	836,544		836,544	(836,544)				34
35	Rent-Equipment & Vehicles			15,093	15,093		15,093		15,093			35
36	Other (specify):*											36
37	TOTAL Ownership			949,113	949,113		949,113	168,826	1,117,939			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			41,749	41,749		41,749		41,749			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			326,187	326,187		326,187		326,187			42
43	Other (specify):* Outpatient Care			115	115		115		115			43
44	TOTAL Special Cost Centers			368,051	368,051		368,051		368,051			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,482,984	991,765	3,824,105	8,298,854		8,298,854	103,596	8,402,450			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: 10/1/13

Ending: 9/30/14

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,321)	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	(28,788)	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	18,223	V-27		24
25	Fund Raising, Advertising and Promotional	(74,163)	V-20		25
	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	(58,398)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,447)		\$	30

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	2	
		Amount	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)	231,475		34
35	Other- Attach Schedule See Att Sch III	16,568		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 248,043		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 103,596		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Jerseyville Manor

ID# 0047597

Report Period Beginning: 10/1/13

Ending: 9/30/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

10/1/13

Ending:

9/30/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	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

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning:

10/1/13

Ending:

Summary B

9/30/14

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

	Capital Expense	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)	
	D. Ownership													
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	231,475	0	0	0	0	0	0	0	0	0	231,475	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	231,475	0	0	0	0	0	0	0	0	0	231,475	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	231,475	0	0	0	0	0	0	0	0	0	231,475	45

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 836,544	Jerseyville North State, LLC	N/A	\$ 1,068,019	\$ 231,475	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			\$ 1,068,019	\$ * 231,475	14

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

Facility Name & ID Number

Jerseyville Manor

0047597

Report Period Beginning:

10/1/13

Ending:

9/30/14

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: 10/1/13 Ending: 9/30/14

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								\$ 3,773	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	\$ 3,773		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:

10/1/13

Ending: 9/30/14

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 NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							16,568	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				\$	\$		\$	16,568

Facility Name & ID Number

Jerseyville Manor

0047597

Report Period Beginning:

10/1/13

Ending:

9/30/14

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	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	4,022,987	3/1/2046	3.5500	143,933	2						
3												3						
4	Community Living											4						
5	Options, Inc.	X		Wing addition		8/1/2009	5,738,601	5,738,601	7/1/2039	6.0000	344,316	5						
	Working Capital																	
6	Miscellaneous		X									6						
7	Less Interest Income		X								(28,788)	7						
8												8						
9	TOTAL Facility Related				\$17,694.29		\$ 9,911,701	\$ 9,761,588			\$ 459,461	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	\$ 9,761,588			\$ 459,461	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,242 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	92,602		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.)		\$	126,179		2
3. Under or (over) accrual (line 2 minus line 1).		\$	33,577		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	95,006		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.		\$	128,583		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	111,236	8	FOR BHF USE ONLY	
	2010	113,784	9		
	2011	116,445	10	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2012	123,322	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	126,179	12	15	LESS REFUND FROM LINE 6 \$ 15
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
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 2013 bill.					

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.

2013 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 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-127-014-00</u>	<u>S17 T8 R11 UNPLATTED</u>	\$ <u>124,929.68</u>	\$ <u>124,929.68</u>
2. _____	<u>PARCELS PT SE 1/4 (TRACT</u>	\$ _____	\$ _____
3. _____	<u>1 - SURVEY IN PLAT CAB 1/54B)</u>	\$ _____	\$ _____
4. <u>04-127-015-00</u>	<u>S17 T8 R11 UNPLATTED</u>	\$ <u>707.02</u>	\$ <u>707.02</u>
5. _____	<u>PARCELS PT SE 1/4 (PT TRACT</u>	\$ _____	\$ _____
6. _____	<u>2 PLAT CAB 1/54B)</u>	\$ _____	\$ _____
7. <u>04-127-014-50</u>	<u>S17 T8 R11 TRACT IN SE1/4</u>	\$ <u>345.64</u>	\$ <u>345.64</u>
8. _____	<u>(PT TRACT 2 SURVEY PC1/54B)</u>	\$ _____	\$ _____
9. <u>04-017-009-00</u>	<u>S17 T8 R11 TRACT IN SE1/4</u>	\$ <u>196.28</u>	\$ <u>196.28</u>
10. _____	<u>SE 1/4 9-04 85K, 10-00 75K</u>	\$ _____	\$ _____
TOTALS		\$ <u><u>126,178.62</u></u>	\$ <u><u>126,178.62</u></u>

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

10/1/13 Ending:

9/30/14

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 (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? (a) Own the Equipment (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 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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92	2005		\$ 4,578,867	\$ 114,474	40	\$ 114,474	\$	\$ 1,039,785	4
5	68	2008		4,926,175	197,047	25	197,047		1,182,282	5
6										6
7										7
8										8
Improvement Type**										
9	Attic Insulation	2005		5,952	397	15	397		3,571	9
10	Parking Lot Lighting	2006		5,355	357	15	357		3,035	10
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop	2008		13,072	170	5-15 yrs	170		11,620	11
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwks	2008		398,166	41,138	5-20 yrs	41,138		256,357	12
13	Landscaping, Fence	2008		47,677	4,488	10-15 yrs	4,488		26,918	13
14	Electric Install, Recliner Wheelchairs, Baskets	2008		37,076	2,852	13	2,852		16,874	14
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over	2008		15,149	1,515	10	1,515		8,837	15
16	Roof	2008		116,316	11,631	10	11,631		68,820	16
17	Paint & Wallpaper, Paint & Wallpaper, Fence	2008		16,441	333	5-8 yrs	333		15,722	17
18	Wndw Decs, Duct work, Veranda, outside lights, Jrsyvile Parking Lot	2009		265,075	25,858	5-15 yrs	25,858		179,007	18
19	Water heater	2010		4,760	476	10	476		1,904	19
20	Generator	2011		3,825	765	5	765		2,485	20
21	Water heater	2011		4,407	441	10	441		1,359	21
22	Lobby Remodel (Contracted Total)	2011		31,490	2,624	12	2,624		10,496	22
23	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Pain	2012		68,090	5,674	12	5,674		10,875	23
24	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Gra	2012		59,732	4,978	12	4,978		9,541	24
25	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall	2012		29,696	2,475	12	2,475		4,743	25
26	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Ba	2012		30,269	2,522	12	2,522		4,834	26
27	Water Heater	2014		10,185	764	10	764		764	27
28	Water Heater	2014		5,204	390	10	390		390	28
29	Exterior Double Doors	2014		5,641	235	10	235		235	29
30	Courtyard Doors	2014		2,615	73	15	73		73	30
31	Hollow Metal Doors	2014		4,937	103	20	103		103	31
32	Water Softener	2014		3,539	88	10	88		88	32
33	Concrete-Parking Lot	2014		52,000	289	15	289		289	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:

10/1/13

Ending:

9/30/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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)	\$ 10,741,711	\$ 422,157		\$ 422,157	\$	\$ 2,861,007	70

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

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	\$ 849,792	\$ 86,376	\$ 86,376	\$	3-15 yrs	\$ 615,369	71
72	Current Year Purchases	31,851	1,902	1,902		5-15 yrs	1,902	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 881,643	\$ 88,278	\$ 88,278	\$		\$ 617,271	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	2014 Braun Entervan	2014	\$ 41,928	\$ 4,367	\$ 4,367	\$	4 yrs	\$ 4,367	76
77										77
78										78
79										79
80	TOTALS			\$ 41,928	\$ 4,367	\$ 4,367	\$		\$ 4,367	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)	\$ 11,839,307	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 514,802	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 514,802	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)	\$ 3,482,645	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	2003 GMC G3500 Van - 2006	29,848		29,848	88
89					89
90					90
91	TOTALS	\$ 92,246	\$	\$ 92,246	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.

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. 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:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$			7

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. _____ /2015 \$ N/A

13. _____ /2016 \$ N/A

14. _____ /2017 \$ N/A

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: 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: \$ 15,093

Description: See Attached Schedule X

(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: 10/1/13 Ending: 9/30/14
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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.

Facility Name & ID Number Jerseyville Manor

0047597

Report Period Beginning: 10/1/13

Ending:

9/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 148,243	\$ 600,779	1
2	Cash-Patient Deposits	23,457	23,457	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 212,000)	1,401,167	1,401,167	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,606	141,233	6
7	Other Prepaid Expenses	4,974	4,974	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	6,293,750	6,310,408	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,001,197	\$ 8,482,018	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	843,635	1,236,669	15
16	Equipment, at Historical Cost	360,291	1,015,817	16
17	Accumulated Depreciation (book methods)	(639,825)	(3,574,891)	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		338,508	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 564,101	\$ 8,695,170	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,565,298	\$ 17,177,188	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 184,401	\$ 184,401	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,457	23,457	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,101	92,101	30
31	Accrued Taxes Payable (excluding real estate taxes)	109,225	109,225	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,006	32
33	Accrued Interest Payable		364,849	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		70,658	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 409,184	\$ 1,261,519	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		5,738,601	39
40	Mortgage Payable		3,952,329	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	Security Deposits	45,000	45,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,000	\$ 9,735,930	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 454,184	\$ 10,997,449	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,111,114	\$ 6,179,739	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,565,298	\$ 17,177,188	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,635,172	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,635,172	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,475,942	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)	\$ 1,475,942	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)	\$ 8,111,114	24 *

* This must agree with page 17, line 47.

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.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 9,263,374	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,263,374	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	460,344	6	
7	Oxygen	81	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 460,425	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	1,140	12	
13	Barber and Beauty Care	3,930	13	
14	Non-Patient Meals	1,321	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,391	23	
D. Non-Operating Revenue				
24	Contributions	83	24	
25	Interest and Other Investment Income***	28,788	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,871	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Durable Medical Equipment	3,604	28	
28a	Miscellaneous Income	12,131	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,735	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,774,796	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,424,424	31	
32	Health Care	4,070,172	32	
33	General Administration	1,487,094	33	
B. Capital Expense				
34	Ownership	949,113	34	
C. Ancillary Expense				
35	Special Cost Centers	41,864	35	
36	Provider Participation Fee	326,187	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,298,854	40	
41	Income before Income Taxes (line 30 minus line 40)**	1,475,942	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,475,942	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,255,572	44
45	Private Pay - Net Inpatient Revenue	2,095,622	45
46	Medicare - Net Inpatient Revenue	3,506,457	46
47	Other-(specify) <u>Medicare Replacement Insurance</u>	320,846	47
48	Other-(specify) <u>See Att Schedule XI</u>	84,877	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,263,374	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:

10/1/13

Ending:

9/30/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,080	\$ 74,807	\$ 35.96	1
2	Assistant Director of Nursing	1,220	1,281	31,994	24.98	2
3	Registered Nurses	26,938	27,997	606,720	21.67	3
4	Licensed Practical Nurses	14,085	14,807	268,987	18.17	4
5	CNAs & Orderlies	121,993	128,249	1,336,918	10.42	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	8,144	8,733	88,675	10.15	10
11	Social Service Workers	3,796	4,052	57,836	14.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,971	29,326	284,794	9.71	15
16	Dishwashers					16
17	Maintenance Workers	5,715	6,243	83,553	13.38	17
18	Housekeepers	18,817	19,533	184,466	9.44	18
19	Laundry	6,000	6,373	55,941	8.78	19
20	Administrator	1,928	2,080	110,680	53.21	20
21	Assistant Administrator	1,888	2,080	39,287	18.89	21
22	Other Administrative	1,932	2,080	51,993	25.00	22
23	Office Manager					23
24	Clerical	5,330	5,642	76,087	13.49	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	1,209	1,311	15,657	11.94	31
32	Other Health Care(specify)	5,576	5,975	114,589	19.18	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	254,494	267,842	\$ 3,482,984 *	\$ 13.00	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	***	\$ 8,975	1-3	35
36	Medical Director	***	14,400	9-3	36
37	Medical Records Consultant	***	858	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	9,727	10-3	39
40	Physical Therapy Consultant	***	463,254	10a-3	40
41	Occupational Therapy Consultant	***	408,927	10a-3	41
42	Respiratory Therapy Consultant	***	17,146	10a-3	42
43	Speech Therapy Consultant	***	170,278	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify)	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		\$ 1,093,565		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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: 10/1/13

Ending: 9/30/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Dana Bainter	Administrator	None	\$ 110,680	Workers' Compensation Insurance	\$ 120,015	IDPH License Fee	\$		
Mary Mosby	Asst Admin	None	39,287	Unemployment Compensation Insurance	23,551	Advertising: Employee Recruitment		286	
				FICA Taxes	258,323	Health Care Worker Background Check			
				Employee Health Insurance	168,391	(Indicate # of checks performed 89)		2,680	
				Employee Meals		Patient Background Checks	182	1,820	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion		74,163	
				401 (k)	18,392	Subscriptions		258	
				Other Employee Benefits	5,717	IHCA Dues		5,426	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 149,967			Other Licenses & Fees		3,821	
B. Administrative - Other						Indirect Costs - See Att Sch III		3	
Description			Amount			Less: Public Relations Expense	(
			\$			Non-allowable advertising		(74,163)	
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 594,389		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,294
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
RFMS, Inc	Administrative Services		\$ 171,600			\$	Out-of-State Travel	\$	
McGladrey LLP	Accounting Services		17,092						
LTC Support Services, LLC	Support Services		144,775						
Blue Orange	Consulting Services		1,072				In-State Travel		
Polsinelli PC	Legal Services		1,105				Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	0	
Norbert J Goetten	Collection Services		2,761				Seminar Expense	985	
							Less: non-allowable out-of-state travel	0	
							Indirect costs - See Att Sch III	0	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 338,405	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 985	

* Attach copy of IMRF notifications

**See instructions.

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	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:

10/1/13

Ending: 9/30/14

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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,766 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. \$ 326,187
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. \$ 1,321
- (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 of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details Yes-See Att Sch XII
Attach invoices and a summary of services for all architect and appraisal fees.