FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

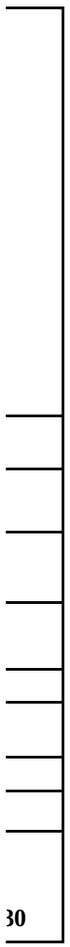
I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/14 to 9/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (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) RSM US 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) 782-163


30

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	25,129	12,433	7,804	45,366	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,129	12,433	7,804	45,366	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.68%

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 6,167

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: 9/30/15 Fiscal Year: 9/30/15

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	304,309	32,087	13,940	350,336		350,336		350,336			1
2	Food Purchase		444,665		444,665		444,665	(984)	443,681			2
3	Housekeeping	188,029	47,842		235,871		235,871		235,871			3
4	Laundry	73,373	40,747		114,120		114,120		114,120			4
5	Heat and Other Utilities			165,617	165,617		165,617		165,617			5
6	Maintenance	86,350	45,151	63,981	195,482		195,482		195,482			6
7	Other (specify):*											7
8	TOTAL General Services	652,061	610,492	243,538	1,506,091		1,506,091	(984)	1,505,107			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,635,433	441,225	10,554	3,087,212		3,087,212		3,087,212			10
10a	Therapy			1,067,992	1,067,992		1,067,992		1,067,992			10a
11	Activities	96,437	3,235		99,672		99,672		99,672			11
12	Social Services	62,639			62,639		62,639		62,639			12
13	CNA Training			1,873	1,873							13
14	Program Transportation			809	809	3,113	3,922		3,922			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,794,509	444,460	1,095,628	4,334,597	3,113	4,335,837		4,335,837			16
	C. General Administration											
17	Administrative	150,785			150,785		150,785		150,785			17
18	Directors Fees							3,933	3,933			18
19	Professional Services			334,613	334,613		334,613	1,519	336,132			19
20	Dues, Fees, Subscriptions & Promotions			71,264	71,264		71,264	(57,186)	14,078			20
21	Clerical & General Office Expenses	76,064	42,866	54,040	172,970		172,970	(1,420)	171,550			21
22	Employee Benefits & Payroll Taxes			585,275	585,275		585,275		585,275			22
23	Inservice Training & Education			3,448	3,448		3,448		3,448			23
24	Travel and Seminar			434	434		434		434			24
25	Other Admin. Staff Transportation			6,226	6,226	(3,113)	3,113		3,113			25
26	Insurance-Prop.Liab.Malpractice			96,238	96,238		96,238	38,359	134,597			26
27	Other (specify):* See attch Sch V	52,949		83,950	136,899		136,899	(136,899)				27
28	TOTAL General Administration	279,798	42,866	1,235,488	1,558,152	(3,113)	1,555,039	(151,694)	1,403,345			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,726,368	1,097,818	2,574,654	7,398,840		7,396,967	(152,678)	7,244,289			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: 10/1/14 Ending: 9/30/15

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			103,798	103,798		103,798	416,245	520,043			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							483,288	483,288			32
33	Real Estate Taxes			980	980		980	137,400	138,380			33
34	Rent-Facility & Grounds			836,544	836,544		836,544	(836,544)				34
35	Rent-Equipment & Vehicles			21,288	21,288		21,288		21,288			35
36	Other (specify):*											36
37	TOTAL Ownership			962,610	962,610		962,610	200,389	1,162,999			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			40,085	40,085		40,085		40,085			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			321,354	321,354		321,354		321,354			42
43	Other (specify):* Outpatient Care			1,916	1,916		1,916		1,916			43
44	TOTAL Special Cost Centers			363,355	363,355		363,355		363,355			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,726,368	1,097,818	3,900,619	8,724,805		8,722,932	47,711	8,770,643			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: 10/1/14 Ending: 9/30/15

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	(984)	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	(2,493)	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	(1,430)	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	(83,146)	V-27		24
25	Fund Raising, Advertising and Promotional	(57,190)	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	(58,801)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (204,044)		$	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)	238,378		34
35	Other- Attach Schedule	13,377		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 251,755		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 47,711		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

STATE OF ILLINOIS **Page 5A**

Jerseyville Manor

ID# 0047597

Report Period Beginning: 10/1/14

Ending: 9/30/15

	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:** 10/1/14 **Ending:** 9/30/15

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

Summary B

Facility Name & ID Number Jerseyville Manor # 0047597 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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	238,378	0	0	0	0	0	0	0	0	0	238,378	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	238,378	0	0	0	0	0	0	0	0	0	238,378	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	238,378	0	0	0	0	0	0	0	0	0	238,378	45

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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 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	$ 1,074,922	$ 238,378	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			$ 1,074,922	$ * 238,378	14

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

Facility Name & ID Number Jerseyville Manor # 0047597 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

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: 10/1/14 Ending: 9/30/15

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								$ 3,933	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	$ 3,933		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: 10/1/14 Ending: 9/30/15

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							13,377	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					$	$		$ 13,377	25

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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**		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	5/1/12	4,173,100	3,952,329	3/1/2046	3.5500	141,465	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								(2,493)	7
8												8
9	TOTAL Facility Related				$17,694.29		$ 9,911,701	$ 9,690,930			$ 483,288	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	$ 9,690,930			$ 483,288	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 19,893 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: 10/1/14 Ending: 9/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	95,006	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.)	$	133,834	2
3. Under or (over) accrual (line 2 minus line 1).	$	38,828	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	99,552	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.	$	138,380	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	113,784	8
	2011	116,445	9
	2012	123,322	10
	2013	126,179	11
	2014	133,834	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 2014 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 132,487.54	$ 132,487.54
2.		PARCELS PT SE 1/4 (TRACT	$	$
3.		1 - SURVEY IN PLAT CAB 1/54B)	$	$
4.	04-127-015-00	S17 T8 R11 UNPLATTED	$ 749.68	$ 749.68
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	$ 366.66	$ 366.66
8.		(PT TRACT 2 SURVEY PC1/54B)	$	$
9.	04-017-009-00	S17 T8 R11 TRACT IN SE1/4	$ 229.82	$ 229.82
10.		SE 1/4 9-04 85K, 10-00 75K	$	$
		TOTALS	$ 133,833.70	$ 133,833.70

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

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	$	$ 1,154,257
5	68		2008		4,926,175	197,047	25	197,047		1,379,329
6										
7										
8										
	Improvement Type**									
9	Attic Insulation			2005	5,952	397	15	397		3,968
10	Parking Lot Lighting			2006	5,355	357	15	357		3,392
11	Furnace, Wall Paper/Paint Dining/Kitchen/Beauty Shop			2008	13,072	168	5-15 yrs	168		11,788
12	Floor Scrubber, Elec Sign, Prking Lot, Renten Pnd, Sidwlks			2008	398,166	41,132	5-20 yrs	41,132		297,489
13	Landscaping, Fence			2008	47,677	4,487	10-15 yrs	4,487		31,405
14	Electric Install, Recliner Wheelchairs, Baskets			2008	37,076	2,852	13	2,852		19,726
15	Dish Truck, Steamable, Convect. Steamer, Wiring Convec Over			2008	15,149	1,515	10	1,515		10,352
16	Roof			2008	116,316	11,632	10	11,632		80,452
17	Paint & Wallpaper, Paint & Wallpaper, Fence			2008	16,441	332	5-8 yrs	332		16,054
18	Wndw Decs, Duct work, Veranda, outsde lights, Jrsyvile Parking Lot			2009	265,075	21,135	5-15 yrs	21,135		200,142
19	Water heater			2010	4,760	476	10	476		2,380
20	Generator, Water heater, lobby remodel (Contracted Total)			2011	39,722	3,830	5-12 yrs.	3,830		18,170
21	Bathroom #1- Fixtures/Plumbing/Toilet/Drywall/Cabinets/Tile Floor/Paint			2012	68,090	5,674	12	5,674		16,549
22	Bathroom #2- Drywall/Plumbing/Fixtures/Cabinets/Tile Floor/Toilet/ Grab			2012	59,732	4,977	12	4,977		14,518
23	Bathroom #3- Fixtures/Plumbing/Toilet/Cabinets/Paint/ Drywall			2012	29,696	2,475	12	2,475		7,218
24	Bathroom #4- Fixtures/Drywall/Paint/Cabinets/Toilet/Tile Floor/ Grab Bar			2012	30,269	2,522	12	2,522		7,356
25	Water heater			2014	10,185	1,018	10	1,018		1,782
26	Water heater			2014	5,204	521	10	521		911
27	Exterior Double Doors			2014	5,641	564	10	564		799
28	Courtyard Doors			2014	2,615	174	15	174		247
29	Hollow Metal Doors			2014	4,937	247	20	247		350
30	Water Softener			2014	3,539	354	10	354		442
31	Concrete-Parking Lot			2014	52,000	3,467	15	3,467		3,756
32	Concrete Driveway			2015	25,040	556	15	556		556
33	Furnace/AC			2015	6,800	170	10	170		170
34	Carpet Therapy Room			2015	2,791	47	5	47		47
35										
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


4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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			$	$		$	$	$
38								
39								
40								
41								
42								
43								
44								
45								
46								
47								
48								
49								
50								
51								
52								
53								
54								
55								
56								
57								
58								
59								
60								
61								
62								
63								
64								
65								
66								
67								
68								
69								
70	TOTAL (lines 4 thru 69)		$ 10,776,342	$ 422,598		$ 422,598	$	$ 3,283,605

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

37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 881,643	$ 84,682	$ 84,682	$	3-15 yrs	$ 701,953	71
72	Current Year Purchases	80,176	2,281	2,281		7-12 yrs	2,281	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 961,819	$ 86,963	$ 86,963	$		$ 704,234	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	$ 10,482	$ 10,482	$	4 yrs	$ 14,849	76
77										77
78										78
79										79
80	TOTALS			$ 41,928	$ 10,482	$ 10,482	$		$ 14,849	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)	$ 11,954,114	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 520,043	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 520,043	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)	$ 4,002,688	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	Construction in Progress	$ 404,690	92
93			93
94			94
95		$ 404,690	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: 10/1/14 Ending: 9/30/15

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.	/2016	$ N/A
13.	/2017	$ N/A
14.	/2018	$ 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: $ 21,288 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: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/15 (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	$ 99,632	$ 506,181	1
2	Cash-Patient Deposits	34,650	34,650	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 170,000)	1,443,477	1,443,477	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	106,782	133,783	6
7	Other Prepaid Expenses	2,982	2,982	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	7,322,116	7,337,606	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 9,009,639	$ 9,458,679	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	0		12
13	Land	0	174,025	13
14	Buildings, at Historical Cost	0	9,505,042	14
15	Leasehold Improvements, at Historical Cost	878,266	1,271,300	15
16	Equipment, at Historical Cost	440,467	1,095,993	16
17	Accumulated Depreciation (book methods)	(743,623)	(4,094,934)	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 (spe **Replacement Reserve**		310,485	22
23	Other(specify): Construction in Progress		404,690	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 575,110	$ 8,666,601	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,584,749	$ 18,125,280	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,004	$ 259,004	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,650	34,650	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,070	74,070	30
31	Accrued Taxes Payable (excluding real estate taxes)	114,017	114,017	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	99,552	32
33	Accrued Interest Payable	0	356,008	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	0	171,822	36
37	Current Portion of long term payable	0	73,207	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 481,741	$ 1,182,330	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,738,601	39
40	Mortgage Payable	0	3,879,122	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Construction Payable		404,690	43
44	Security Deposits	40,500	40,500	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 40,500	$ 10,062,913	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 522,241	$ 11,245,243	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,062,508	$ 6,880,037	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,584,749	$ 18,125,280	48

*(See instructions.)

Facility Name & ID Number Jerseyville Manor **#** 0047597 **Report Period Beginning:** 10/1/14 **Ending:** 9/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,111,114	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,111,114	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	951,394	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)**	$ 951,394	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)**	$ 9,062,508	24 *

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

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	$ 9,144,649	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,144,649	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	505,989	6
7	Oxygen	135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 506,124	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	1,161	12
13	Barber and Beauty Care	6,072	13
14	Non-Patient Meals	984	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**	$ 8,217	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,493	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,493	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Durable Medical Equipment	1,796	28
28a	Miscellaneous Income	12,920	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,716	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,676,199	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,506,091	31
32	Health Care	4,334,597	32
33	General Administration	1,558,152	33
	B. Capital Expense		
34	Ownership	962,610	34
	C. Ancillary Expense		
35	Special Cost Centers	42,001	35
36	Provider Participation Fee	321,354	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,724,805	40
41	**Income before Income Taxes (line 30 minus line 40)****	951,394	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 951,394	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,451,398	44
45	Private Pay - Net Inpatient Revenue	2,070,054	45
46	Medicare - Net Inpatient Revenue	3,142,614	46
47	Other-(specify) Medicare Replacement Insurance	24,788	47
48	Other-(specify) See Att Schedule XI	455,795	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,144,649	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: 10/1/14 Ending: 9/30/15

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	1,904	2,088	$ 70,502	$ 33.77	1
2	Assistant Director of Nursing	1,156	1,230	30,487	24.79	2
3	Registered Nurses	24,258	25,796	556,288	21.56	3
4	Licensed Practical Nurses	19,969	21,141	395,138	18.69	4
5	CNAs & Orderlies	124,760	131,243	1,432,553	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,895	9,545	96,437	10.10	10
11	Social Service Workers	3,811	4,086	62,639	15.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,105	30,592	304,309	9.95	15
16	Dishwashers					16
17	Maintenance Workers	5,868	6,284	86,350	13.74	17
18	Housekeepers	18,806	20,293	188,029	9.27	18
19	Laundry	7,851	8,295	73,373	8.85	19
20	Administrator	1,584	1,794	110,005	61.32	20
21	Assistant Administrator	1,888	2,080	40,780	19.61	21
22	Other Administrative	1,928	2,080	52,949	25.46	22
23	Office Manager					23
24	Clerical	5,192	5,595	76,064	13.59	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	1,782	1,992	20,814	10.45	31
32	Other Health Care(specify)	5,652	6,182	129,651	20.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	264,409	280,316	$ 3,726,368 *	$ 13.29	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	***	$ 13,940	1-3
36	Medical Director	***	14,400	9-3
37	Medical Records Consultant	***	2,000	10-3
38	Nurse Consultant	***	0	10-3
39	Pharmacist Consultant	***	8,554	10-3
40	Physical Therapy Consultant	***	471,670	10a-3
41	Occupational Therapy Consultant	***	386,835	10a-3
42	Respiratory Therapy Consultant	***	29,061	10a-3
43	Speech Therapy Consultant	***	180,426	10a-3
44	Activity Consultant	***		11-3
45	Social Service Consultant	***		12-3
46	Other(specify)	***		10-3
47				
48	*** Monthly Fee			
49	TOTAL (lines 35 - 48)		$ 1,106,886	

C. CONTRACT NURSES

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

35
36
37
38
39
40
41
42
43
44
45
46
47
48
49

50
51
52
53

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dana Bainter	Administrator	None	$ 110,005
Mary Mosby	Asst Admin	None	40,780
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 150,785

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
RSM US LLP	Accounting Services	24,422
LTC Support Services, LLC	Support Services	133,320
Norbert J. Goetten	Collection Services	3,526
Hepler Broom LLC	Legal Services	222
Duane Morris, LLP	Legal Services	1,522
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 334,613

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,543
Unemployment Compensation Insurance	23,516
FICA Taxes	280,728
Employee Health Insurance	157,879
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	18,788
Other Employee Benefits	6,821
TOTAL (agree to Schedule V, line 22, col.8)	$ 585,275

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	201
Health Care Worker Background Check	
(Indicate # of checks performed 61)	500
Patient Background Checks 178	2,000
Advertising - Promotion	57,190
Subscriptions	671
IHCA Dues	8,134
Other Licenses & Fees	2,568
Indirect Costs - See Att Sch III	4
Less: Public Relations Expense	( )
Non-allowable advertising	(57,190)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,078

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	434
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)	$ 434

**See instructions.

Facility Name & ID Number Jerseyville Manor # 0047597 Report Period Beginning: 10/1/14 Ending: 9/30/15

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: 10/1/14 Ending: 9/30/15

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? **9 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,117** 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. $ **321,354**
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. $ **984**

(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: **RSM US 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) 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.