

		FOR BHF USE			

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p>I. Facility ID Number: 1000132</p> <p>Facility Name: <u>Jerseyville Estates</u></p> <hr/> <p>Address: <u>1210 E Fairgrounds</u> <u>Jerseyville</u> <u>62052</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Jersey</u></p> <p>Telephone Number: (<u>618</u>) <u>639-9700</u> Fax # (<u>618</u>) <u>639-9701</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>8/1/2011</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Deborah J Edwards</u> Telephone Number: (<u>618</u>) <u>233-1001</u></p> <p>Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</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" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>J. Michael Greer</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Partner</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Creason-Edwards & Cimarolli</u> <u>4000 N Belt West, Belleville, IL 62226</u></td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u>618</u>) <u>233-1001</u> Fax <u>618-233-6009</u></td> <td></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE IL DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>J. Michael Greer</u>			(Title) <u>Partner</u>		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u>			(Firm Name & Address) <u>Creason-Edwards & Cimarolli</u> <u>4000 N Belt West, Belleville, IL 62226</u>			(Telephone) (<u>618</u>) <u>233-1001</u> Fax <u>618-233-6009</u>	
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Facility Name Jerseyville Estates

Report Period Beginning: 1/1/16 Ending: 12/31/16

III. STATISTICAL DATA

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

Date of change in certified units / /

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	30	Single Unit Apartment	30	10,950	1
2	20	Double Unit Apartment	44	14,620	2
3		Other			3
4	50	TOTALS	74	25,570	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	4,969	4,316		9,285	5
6	Double Unit	5,577	6,594		12,171	6
7	Other					7
8	TOTALS	10,546	10,910		21,456	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.91%

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

228 Also, indicate the number of unpaid bed-hold days the SLF had during this year. (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES NO

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2016 Fiscal Year:

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? YES If yes, did the facility make all of the required payments of interest and principle? YES

If no, explain.

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? NO If yes, did the facility make all of the required payments of interest and principle?

If no, explain.

Facility Name: Jerseyville Estates

Report Period Beginning:

1/1/16

Ending:

12/31/16

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	183,176	131,112	1,973	316,261	(35)	316,226	1
2	Housekeeping, Laundry and Maintenance	105,487	44,306	27,514	177,307		177,307	2
3	Heat and Other Utilities			83,710	83,710	(3,210)	80,500	3
4	Other (specify):			4,993	4,993		4,993	4
5	TOTAL General Services	288,663	175,419	118,189	582,271	(3,245)	579,026	5
B. Health Care and Programs								
6	Health Care/ Personal Care	420,048	7,613	3,203	430,865		430,865	6
7	Activities and Social Services	35,644	4,085	510	40,239	(510)	39,729	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	455,692	11,698	3,713	471,103	(510)	470,593	9
C. General Administration								
10	Administrative and Clerical	89,521	12,978	161,748	264,247		264,247	10
11	Marketing Materials, Promotions and Advertising		19,251	14,021	33,272		33,272	11
12	Employee Benefits and Payroll Taxes			126,700	126,700		126,700	12
13	Insurance-Property, Liability and Malpractice			25,197	25,197		25,197	13
14	Other (specify):							14
15	TOTAL General Administration	89,521	32,229	327,666	449,416		449,416	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	833,877	219,345	449,569	1,502,791	(3,755)	1,499,036	16
Capital Expenses								
D. Ownership								
17	Depreciation			429,971	429,971	3,226	433,197	17
18	Interest			230,053	230,053		230,053	18
19	Real Estate Taxes			36,467	36,467		36,467	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):			33,977	33,977	(30,316)	3,661	22
23	TOTAL Ownership			730,469	730,469	(27,090)	703,379	23
24	GRAND TOTAL (Sum of lines 16 and 23)	833,877	219,345	1,180,037	2,233,259	(30,845)	2,202,414	24

Facility Name: Jerseyville Estates

Report Period Beginning 1/1/16

Ending: 12/31/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 28.74	1
2	Licensed Practical Nurses	3	19.16	2
3	Certified Nurse Assistants	12	11.13	3
4	Activity Director & Assistants	1	11.56	4
5	Social Service Workers			5
6	Head Cook	1	16.41	6
7	Cook Helpers/Assistants	4	10.04	7
8	Dishwashers	4	8.89	8
9	Maintenance Workers	2	11.55	9
10	Housekeepers	3	8.65	10
11	Laundry	1	8.31	11
12	Managers	1	29.47	12
13	Other Administrative			13
14	Clerical	1	13.62	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	34	\$	17

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee		
1	\$	1	
2		2	
Total		\$	3

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2
The Prairies		Carbondale	
Clinton Manor Nursing Home		New Baden	
See attached 2 schedule			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Greer Management Services		Carlyle		Management Co	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES NO

Name of related entity: _____ If yes, what is the value of those services? \$ _____
 (Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Jerseyville Estates

Report Period Beginning:

1/1/16

Ending:

12/31/16

VIII. OWNERSHIP COSTS

A. Purchase price of land 417,352 Year land was acquired 2011

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	50		2011	2011	\$ 5,775,516	\$ 210,019	28	\$ 210,019		\$ 1,137,602	1
2	24		2016	2016	4,131,310	125,191	28	125,191		125,191	2
3			2016	2016	413,860	20,693	15	22,992	2,299	22,992	3
4											4
5											5
Improvement Type											
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 10,320,686	\$ 355,903		\$ 358,202	\$ 2,299	\$ 1,285,785	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 519,191	\$ 74,069	\$ 74,996	927	5	\$ 183,461	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 519,191	\$ 74,069	\$ 74,996	927		\$ 183,461	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Jerseyville Estates

Report Period Beginning: 1/1/16

Ending: 12/31/16

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Greer Mangement Services, Inc (Vehicle Lease)

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

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$			7

8. Is movable equipment rental included in building rental? YES NO

9. Rental amount for movable equipment \$ 505

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		IL Hsg Development Auth		X	Mortgage	4/1/12	\$ 1,000,000	\$ 1,000,000	4/1/32	1.0000	\$ 9,064	1
2		TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	2,244,399	3/1/32	6.0000	142,797	2
3		See Attachment 3 Sch					6,526,505	6,407,181			78,192	3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 10,226,505	\$ 9,651,580			\$ 230,053	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 10,226,505	\$ 9,651,580			\$ 230,053	10

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Jerseyville Estates

Report Period Beginning: 1/1/16

Ending:

12/31/16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 836,156	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	537,274		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,231		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	22,000		8
9	Other(specify): Employee Advance	6,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,423,660	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	417,352		13
14	Buildings, at Historical Cost	10,320,686		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	519,191		16
17	Accumulated Depreciation (book methods)	(1,466,019)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,993		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,942)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Constructin In Progress	722,938		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,528,199	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,951,859	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,928	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,355		30
31	Accrued Taxes Payable	41,993		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	46,843		35
36	Note Payable	75,000		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 213,120	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,663,295		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 9,663,295	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 9,876,415	\$	45
46	TOTAL EQUITY	\$ 2,075,445	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,951,859	\$	47

*(See instructions.)

Facility Name: Jerseyville Estates

Report Period Beginning: 1/1/16

Ending:

12/31/16

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,048,761	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,048,761	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	118,893	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	36	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 118,929	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,634	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,634	14
D. Other Revenue (specify):			
15	Cable TV Income	3,210	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 3,210	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,172,533	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	582,271	19
20	Health Care/ Personal Care	471,103	20
21	General Administration	449,416	21
B. Capital Expense			
22	Ownership	730,469	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 2,233,259	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (60,726)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (60,726)	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 875,118	32
33	Private Pay - Net Inpatient Revenue	1,173,643	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,048,761	37

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

Line	Amount	Description
	2,195	Replacement Tax
	1,466	Tax Credit Amortization
	<u>30,316</u>	Bad Debt Expense
22	<u><u>33,977</u></u>	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
1	(35)	Non-allowable meals not directly related to SLF resident care
3	(3,210)	Non-allowable Cable TV expense
7	(510)	Entertainment
17	3,226	Depreciation adjustment
22	<u>(30,316)</u>	Bad Debt Expense
	<u><u>(30,845)</u></u>	

**Jerseyville Estates
2016**

VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	<u>Name</u> <u>1</u>	<u>City</u> <u>2</u>		
	Manor at Craig Farms	Chester		
	Manor at Mason Woods	Pinckneyville		
	Manor at Salem Woods	Salem		

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Mgmt Svc/Payroll Svc/Vehicle Lse	\$ 121,498	\$ 133,809

Facility Name: Jerseyville Estates

Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. INTEREST EXPENSE

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
		A. Directly Facility Related									
Long-Term											
1	TCAP Tranche Two		X	Mortgage	7/1/12	1,580,705	1,580,705	3/1/32	0.0000	0	1
2	The Bank of Edwardsville		X	Mortgage	7/3/16	4,870,800	4,751,476	11/3/24	3.2500	78,192	2
3	GMS II	X		Operating	1/2/16	75,000	75,000	1/2/17	0.0000	0	3
4	Page Total					6,526,505	6,407,181			78,192	

**Jerseyville Estates
2016**

Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle 2

Model	Vue
Year	2003
Make	Saturn
Vehicle Use	Resident Transportation

Total Rental Expense No Payments made