FOR BHF USE

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Par

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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

I. Facility ID Number: 1000132

Facility Name: Jerseyville Estates

Address: 1210 E Fairgrounds (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

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

Federal Employer ID Number:

Date Current Owners were Certified: 08/01/2011

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Deborah J Edwards **Telephone Number:** (618) 233-1001
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 01/01/17 to 12/31/17 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) J Michael Greer
(Title) Partner

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Deborah J Edwards, CPA
(Firm Name & Address) Creason-Edwards & Cimarolli, PC, 4000 N Belt West, Belleville, IL 62226
(Telephone) (618)233-1001 Fax 618-233-6009

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

Facility Name Jerseyville Estates Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 Unit Days During Report Period	
1	30	Single Unit Apartment	30	10,950	1
2	44	Double Unit Apartment	44	16,060	2
3		Other			3
4	74	TOTALS	74	27,010	4

B. Census-For the entire report period.

	1 Type of Unit	2 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,101	3,892		9,993	5
6	Double Unit	6,657	10,457		17,114	6
7	Other					7
8	TOTALS	12,758	14,349		27,107	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 100.36%

D. Indicate the number of paid bed-hold days the SLF had during this year 79 **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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

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

H. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 2017 Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? YES **If yes, did the facility make all of the required payments of interest and principle?** YES
If no, explain. _____

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

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

Facility Name: Jerseyville Estates **Report Period Beginning: 01/01/17 Ending: 12/31/17**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	202,138	156,098	1,973	360,209		360,209	1
2	Housekeeping, Laundry and Maintenance	207,673	41,338	31,229	280,241		280,241	2
3	Heat and Other Utilities			99,401	99,401	(4,030)	95,371	3
4	Other (specify): Waste Removal			4,920	4,920		4,920	4
5	**TOTAL General Services**	409,811	197,437	137,523	744,771	(4,030)	740,741	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	435,528	4,435	3,032	442,996		442,996	6
7	Activities and Social Services	43,008	5,584	960	49,551	(960)	48,591	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	478,536	10,019	3,992	492,547	(960)	491,587	9
	C. General Administration							
10	Administrative and Clerical	138,098	11,869	233,542	383,509		383,509	10
11	Marketing Materials, Promotions and Advertising		22,783	15,235	38,018		38,018	11
12	Employee Benefits and Payroll Taxes			123,925	123,925		123,925	12
13	Insurance-Property, Liability and Malpractice			27,658	27,658		27,658	13
14	Other (specify):							14
15	**TOTAL General Administration**	138,098	34,652	400,360	573,110		573,110	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,026,445	242,107	541,875	1,810,427	(4,990)	1,805,437	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			531,907	531,907	(27,642)	504,265	17
18	Interest			296,931	296,931		296,931	18
19	Real Estate Taxes			51,100	51,100		51,100	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			165	165		165	21
22	Other (specify): See Attachment 1			62,604	62,604	(58,324)	4,280	22
23	**TOTAL Ownership**			942,707	942,707	(85,966)	856,741	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,026,445	242,107	1,484,582	2,753,134	(90,956)	2,662,178	24

Facility Name: Jerseyville Estates Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 21.55	1
2	Licensed Practical Nurses	3	19.09	2
3	Certified Nurse Assistants	12	12.23	3
4	Activity Director & Assistants	2	11.38	4
5	Social Service Workers			5
6	Head Cook	1	17.14	6
7	Cook Helpers/Assistants	4	9.87	7
8	Dishwashers	5	8.90	8
9	Maintenance Workers	2	14.22	9
10	Housekeepers	3	8.70	10
11	Laundry			11
12	Managers	2	27.13	12
13	Other Administrative			13
14	Clerical	1	14.01	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	36	$	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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
The Prairies	Carbondale	Greer Management Services	Carlyle	Management Co
Clinton Manor Nursing Home	New Baden			
See attached 2 schedule				

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 [X]
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 [X] NO [ ]
If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: Jerseyville Estates **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

VIII. OWNERSHIP COSTS

A. Purchase price of land 403,352 **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	$	$ 1,347,620	1
2	24		2016	2016	413,860	39,317	15	27,591	(11,726)	50,583	2
3			2016	2016	4,131,310	150,229	28	150,229		275,421	3
4			2017	2017	592,914	17,069	28	17,967	898	17,967	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)				$ 10,913,600	$ 416,633		$ 405,806	$ (10,827)	$ 1,691,591	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	$ 603,070	$ 113,662	$ 96,848	(16,814)	5	$ 280,309	18
19	Vehicles	32,247	1,612	1,612	(0)		1,612	19
20	TOTAL (lines 18 and 19)	$ 635,317	$ 115,274	$ 98,460	(16,815)		$ 281,921	20

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

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

Facility Name: Jerseyville Estates **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

IX. RENTAL COSTS

A. Building and Fixed Equipment

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

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

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 [X] NO

9. Rental amount for movable equipment $ -

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 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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	$ 11,170	1
2	TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	2,236,277	3/1/32	6.0000	137,287	2
3	See Attachment 3 Sch				/ /	6,526,505	6,128,056	/ /		148,474	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 10,226,505	$ 9,364,333			$ 296,931	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 10,226,505	$ 9,364,333			$ 296,931	10

* If there is an option to buy the building, please provide complete details on an attached schedule.
** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Jerseyville Estates **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 961,961	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	658,595		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,591		6
7	Other Prepaid Expenses	76,874		7
8	Accounts Receivable (owners or related parties)	26,400		8
9	Other(specify): Employee Cash Advances	6,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,754,421	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	403,352		13
14	Buildings, at Historical Cost	10,913,600		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	635,317		16
17	Accumulated Depreciation (book methods)	(1,997,927)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,993		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,408)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,966,927	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,721,349	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,514	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,500		30
31	Accrued Taxes Payable	58,601		31
32	Accrued Interest Payable	2,106		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	**Other Accrued Liabilities**	143,381		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 273,102	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	9,364,333		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)**	$ 9,364,333	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 9,637,435	$	45
46	**TOTAL EQUITY**	$ 2,083,914	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,721,349	$	47

***(See instructions.)**

Facility Name: Jerseyville Estates **Report Period Beginning: 01/01/17 Ending: 12/31/17**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 2,749,479	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,749,479	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	180	7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 119,073	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,710	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 3,710	14
	D. Other Revenue (specify):		
15	**Cable TV Income**	4,030	15
16	**Other Income Receipts**	5,443	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 9,473	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,881,735	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	744,771	19
20	Health Care/ Personal Care	492,547	20
21	General Administration	573,110	21
	B. Capital Expense		
22	Ownership	942,707	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)**	$ 2,753,135	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 128,600	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 128,600	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 1,005,388	32
33	Private Pay - Net Inpatient Revenue	1,744,091	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 2,749,479	37

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

Line	Amount	Description
	2,814	Replacement Tax
	1,466	Tax Credit Amortization
	58,324	Bad Debt Expense
22	62,604	

Page 3, Schedule IV - Adjustments

Line	Amount	Description
3	(4,030)	Non-allowable Cable TV expense
7	(960)	Entertainment
17	(27,642)	Depreciation adjustment
22	(58,324)	Bad Debt Expense
	(90,956)	

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VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	Name 1	City 2		
	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	$ 178,291	$160,886

Facility Name: Jerseyville Estates **Report Period Beginning** 1/1/2017 **Ending:** 12/31/2017

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of	Amount of Note		Maturity	Interest Rate	Reporting Period	
		YES	NO		Note	Original	Balance	Date	(4 Digits)	Int. Expense	
	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	4,547,351	11/3/24	3.2500	148,474	2
3	GMS II	X		Operating	1/2/16	75,000	0	1/2/17	0.0000	0	3
4	Page Total					6,526,505	6,128,056			148,474	

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Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

Total Rental Expense **No Payments made**