

		FOR BHF USE			

LL2

Supportive Living Facility

2017

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2017)

Par

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		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Jerseyville Estates</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/17</u> to <u>12/31/17</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
Address: <u>1210 E Fairgrounds</u> <u>Jerseyville</u> <u>62052</u>																											
County: <u>Jersey</u>																											
Telephone Number: (<u>618</u>) <u>639-9700</u> Fax # <u>(618)</u> <u>639-9701</u>																											
Federal Employer ID Number: _____																											
Date Current Owners were Certified: <u>08/01/2011</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>J Michael Greer</u></td><td></td></tr><tr><td>(Title) <u>Partner</u></td><td></td></tr><tr><td></td><td></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>J Michael Greer</u>		(Title) <u>Partner</u>																		
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	(Type or Print Name) <u>J Michael Greer</u>																										
	(Title) <u>Partner</u>																										
Type of Ownership:		<table><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u></td><td></td></tr><tr><td>(Telephone) <u>(618) 233-1001</u> Fax <u>618-233-6009</u></td><td></td></tr><tr><td colspan="2">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</td></tr></table>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u>		(Firm Name & Address) <u>Creason-Edwards & Cimarolli, PC</u> <u>4000 N Belt West, Belleville, IL 62226</u>		(Telephone) <u>(618) 233-1001</u> Fax <u>618-233-6009</u>		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														
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	☐ Other _____																										
In the event there are further questions about this report, please contact:																											
Name: <u>Deborah J Edwards</u> Telephone Number: <u>(618) 233-1001</u>																											
Email Address: _____																											

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		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	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 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	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 ☒

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

ACCUAL	☒	MODIFIED		
CASH*	☐	CASH*	☐	

I. Is your fiscal year identical to your tax year? ☒ 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.

STATE OF ILLINOIS

Page 3

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 1	Supplies 2	Other 3	Total 4			
	A. General Services							
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

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).

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

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		\$ 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 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 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	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		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	\$ 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.

STATE OF ILLINOIS

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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.)

		1	
	I. Revenue	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

		2	
	II. Expenses	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

**Jerseyville Estates
2017**

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

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

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	<u>(58,324)</u>	Bad Debt Expense
	<u><u>(90,956)</u></u>	

**Jerseyville Estates
2017**

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	\$ 178,291	\$160,886

X. INTEREST EXPENSE

1		2		3		4		6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	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	4,547,351	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			

**Jerseyville Estates
2017**

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