

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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 Jerseyville 62052

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 Charitable Corp. ☐ Trust
 ☒ PROPRIETARY Individual ☒ Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other
 ☐ GOVERNMENTAL State County Other

IRS Exemption Code _____

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 01/01/20 to 12/31/20 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 2810 Frank Scott Pkwy Ste 704, Belleville, IL 62223
 (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

STATE OF ILLINOIS

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Facility Name: Jerseyville Estates

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	195,184	143,504	493	339,181	(55,968)	283,213	1
2	Housekeeping, Laundry and Maintenance	112,855	23,303	22,439	158,597	(31,766)	126,831	2
3	Heat and Other Utilities			102,833	102,833	(2,780)	100,053	3
4	Other (specify):			5,413	5,413		5,413	4
5	TOTAL General Services	308,039	166,807	131,178	606,024	(90,514)	515,510	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	373,596	1,252	8,461	383,309	(100,184)	283,125	6
7	Activities and Social Services	56,537	3,411	145	60,093	(14,806)	45,287	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	430,133	4,663	8,606	443,402	(114,990)	328,412	9
	C. General Administration							
10	Administrative and Clerical	162,481	10,618	236,491	409,590	(43,983)	365,607	10
11	Marketing Materials, Promotions and Advertising		26,717	7,466	34,183		34,183	11
12	Employee Benefits and Payroll Taxes			113,434	113,434		113,434	12
13	Insurance-Property, Liability and Malpractice			36,287	36,287		36,287	13
14	Other (specify) : COVID-19 Expenses				35,203		35,203	14
15	TOTAL General Administration	162,481	37,335	393,678	628,697	(43,983)	584,714	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	900,653	208,805	533,462	1,678,123	(249,487)	1,428,636	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			434,871	434,871	16,968	451,839	17
18	Interest			285,060	285,060		285,060	18
19	Real Estate Taxes			78,964	78,964		78,964	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,189	1,189		1,189	21
22	Other (specify) : See Attachment 1			160,211	160,211	(158,745)	1,466	22
23	TOTAL Ownership			960,295	960,295	(141,777)	818,518	23
24	GRAND TOTAL (Sum of lines 16 and 23)	900,653	208,805	1,493,757	2,638,418	(391,264)	2,247,154	24

Facility Name: Jerseyville Estates

Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.00	1
2	Licensed Practical Nurses	2	23.66	2
3	Certified Nurse Assistants	9	13.33	3
4	Activity Director & Assistants	1	17.64	4
5	Social Service Workers			5
6	Head Cook	1	19.67	6
7	Cook Helpers/Assistants	3	12.23	7
8	Dishwashers	4	10.68	8
9	Maintenance Workers	2	15.26	9
10	Housekeepers	2	11.33	10
11	Laundry	1	10.08	11
12	Managers	2	29.88	12
13	Other Administrative			13
14	Clerical	1	18.71	14
15	Marketing			15
16	Other	1	11.50	16
17	Total (lines 1 thru 16)	30	\$	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
Clinton Manor Nursing Home	New Baden
Manor at Craig Farms	Chester
Manor at Mason Woods	Pinckneyville
Manor at Salem Woods	Salem

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

Facility Name: Jerseyville Estates

Report Period Beginning:

01/01/20

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VIII. OWNERSHIP COSTS

A. Purchase price of land 363,352 Year land was acquired 2011 & 2016

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	\$	\$ 1,977,677	1
2	24		2016	2016	4,131,310	150,229	28	150,229		726,109	2
3											3
4											4
5											5
	Improvement Type										
6	Land Improvements		2016	2016	413,860	28,662	15	27,592	(1,070)	133,355	6
7	Land Improvements		2019	2019	24,975	1,665	15	1,665		1,943	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)				\$ 10,345,661	\$ 390,575		\$ 389,505	\$ (1,070)	\$ 2,839,084	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	\$ 529,497	\$ 37,847	\$ 55,885	18,038	5	\$ 455,220	18
19	Vehicles	41,747	6,449	6,449		5	20,961	19
20	TOTAL (lines 18 and 19)		\$ 571,244	\$ 44,296	\$ 62,334		\$ 476,181	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

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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	0.0100	\$ 10,000	1
2	TCAP Tranche One		X	Mortgage	7/1/12	2,700,000	1,924,923	3/1/32	0.0600	119,199	2
3	See Attachment 3 Sch				/ /	6,451,505	5,534,885	/ /		155,861	3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 10,151,505	\$ 8,459,808			\$ 285,060	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 10,151,505	\$ 8,459,808			\$ 285,060	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.

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Facility Name: Jerseyville Estates

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/20

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,119,328	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	779,208		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,415		6
7	Other Prepaid Expenses	18,910		7
8	Accounts Receivable (owners or related parties)	72,700		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,026,561	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	363,352		13
14	Buildings, at Historical Cost	10,345,661		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	571,244		16
17	Accumulated Depreciation (book methods)	(3,321,788)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	21,993		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,807)		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)	\$ 7,966,655	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,993,216	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,277	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,332		30
31	Accrued Taxes Payable	78,661		31
32	Accrued Interest Payable	5,639		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Accrued Liabilities	42,244		35
36	PPP Loan	244,350		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 430,503	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	8,459,808		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)	\$ 8,459,808	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,890,311	\$	45
46	TOTAL EQUITY	\$ 1,102,905	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,993,216	\$	47

*(See instructions.)

Facility Name: Jerseyville Estates

Report Period Beginning: 01/01/20

Ending:

12/31/20

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	\$ 2,449,983	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,449,983	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	69	7
8	Barber and Beauty Care		8
9	Non-Resident Meals	2,212	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 121,174	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	6,769	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 6,769	14
	D. Other Revenue (specify):		
15	Cable TV Income	2,780	15
16	Other Income: See Attachment 1	597,500	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 600,280	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,178,206	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	606,024	19
20	Health Care/ Personal Care	443,402	20
21	General Administration	628,697	21
	B. Capital Expense		
22	Ownership	960,295	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)	\$ 2,638,418	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 539,788	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 539,788	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,142,947	32
33	Private Pay - Net Inpatient Revenue	1,307,036	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,449,983	37

**Jerseyville Estates
2020**

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

Line	Amount	Description
	-	Replacement Tax
	1,466	Tax Credit Amortization
	<u>158,745</u>	Bad Debt Expense
22	<u><u>160,211</u></u>	

Page 3, Schedule IV - Column 5 Adjustments

Line	Amount	Description
	(2,212)	Non-allowable meals not directly related to SLF resident care
	<u>(53,756)</u>	*PPP- Payroll Costs
1	(55,968)	
2	(31,766)	*PPP - Payroll Costs
3	(2,780)	Non-allowable Cable TV expense
6	(100,184)	*PPP - Payroll Costs
	(145)	Entertainment
	<u>(14,661)</u>	*PPP - Payroll Costs
7	(14,806)	
10	(43,983)	*PPP - Payroll Costs
17	16,968	Depreciation adjustment
22	<u>(158,745)</u>	Bad Debt Expense
	<u><u>(391,264)</u></u>	
	*PPP Loan of \$244,350 Forgiven on 02/05/2021	

Page 8, Schedule XII, Section I - Other income:

Line	Amount	Description
	47,769	Sundry Income
	480,123	Cares Act Grant
	<u>69,608</u>	Provider Relief Fund
16	<u><u>597,500</u></u>	

**Jerseyville Estates
2020**

VII: RELATED ORGANIZATIONS

A.	RELATED SLF's & HEALTH CARE BUSINESSES			
	<u>Name</u> <u>1</u>	<u>City</u> <u>2</u>		
	Cottages at Salem, Inc	Salem		
	Cottages at Carlinville, Inc	Carlinville		

C.	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
	Greer Management Services, Inc.	Mgmt Svc/Payroll Svc/Vehicle Lse	\$ 226,409	\$210,549

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	3,954,180	11/3/24	0.0325	155,861	2		
3											3		
4	Page Total					6,451,505	5,534,885			155,861			

**Jerseyville Estates
2020**

Page 6, Schedule IX - Item 10

Vehicle 1

Model	Grand Caravan
Year	2010
Make	Dodge
Vehicle Use	Resident Transportation

Vehicle 2

Model	Explorer
Year	2004
Make	Ford
Vehicle Use	Resident Transportation

Total Rental Expense	No Payments made
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