FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 Name: Courtyard Estates of Sullivan

Address: 20 Courtyard Boulevard (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4300 **Fax #** (217) 728-2165

Federal Employer ID Number: 74-3055934

Date Current Owners were Certified: 9/30/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:**
Email Address: ltemplin@thepetersencompanies.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2009 to 12/31/2009 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) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: Courtyard Estates of Sullivan Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

Date of change in certified units: N/A

	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	50	Single Unit Apartment	50	18,250	1
2		Double Unit Apartment			2
3		Other			3
4	50	TOTALS	50	18,250	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	4,244	4,945		9,189	5
6	Double Unit					6
7	Other					7
8	TOTALS	4,244	4,945		9,189	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 50.35%

D. Indicate the number of paid bed-hold days the SLF had during this year None **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** None **(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 [X] NO [ ] Non-allowable costs have been eliminated in Schedule IV, Column 5

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)
N/A

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/2009 Fiscal Year: 12/31/2009
* All facilities other than governmental must report on the accrual basis.

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

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?** N/A
If no, explain. N/A

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?** N/A
If no, explain. N/A

Facility Name: Courtyard Estates of Sullivan **Report Period Beginning: 1/1/2009 Ending: 12/31/2009**

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	61,802	46,500		108,302	(94)	108,208	1
2	Housekeeping, Laundry and Maintenance	12,923	10,198	10,450	33,571		33,571	2
3	Heat and Other Utilities			51,274	51,274		51,274	3
4	Other (specify):							4
5	**TOTAL General Services**	74,725	56,698	61,724	193,147	(94)	193,053	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	129,137	625		129,762		129,762	6
7	Activities and Social Services		850	168	1,018		1,018	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	129,137	1,475	168	130,780		130,780	9
	C. General Administration							
10	Administrative and Clerical	35,728	1,192	11,187	48,107	45,000	93,107	10
11	Marketing Materials, Promotions and Advertising		145		145	(145)		11
12	Employee Benefits and Payroll Taxes			29,458	29,458		29,458	12
13	Insurance-Property, Liability and Malpractice			6,191	6,191		6,191	13
14	Other (specify): Telephone			2,192	2,192		2,192	14
15	**TOTAL General Administration**	35,728	1,337	49,028	86,093	44,855	130,948	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	239,590	59,510	110,920	410,020	44,761	454,781	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			212,630	212,630	(14,339)	198,291	17
18	Interest			325,785	325,785		325,785	18
19	Real Estate Taxes			94,455	94,455		94,455	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			4,438	4,438		4,438	21
22	Other (specify): Non-allowable expenses			26,133	26,133	(26,133)		22
23	**TOTAL Ownership**			663,441	663,441	(40,472)	622,969	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	239,590	59,510	774,361	1,073,461	4,289	1,077,750	24

Facility Name: Courtyard Estates of Sullivan **Report Period Beginning 1/1/2009 Ending: 12/31/2009**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		$	1
2	Licensed Practical Nurses	1	17.79	2
3	Certified Nurse Assistants	4	9.62	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.27	6
7	Cook Helpers/Assistants	2	9.12	7
8	Dishwashers			8
9	Maintenance Workers	1	13.03	9
10	Housekeepers	1	8.01	10
11	Laundry			11
12	Managers	1	28.85	12
13	Other Administrative	1	18.50	13
14	Clerical	1	10.19	14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	13	$	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	N/A			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	$	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
See Attached Schedule 4B									

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

Name of related entity: Petersen Health Care, Inc. **If yes, what is the value of those services? $** 85,376

(Please attach a separate schedule itemizing those services.) **The services were for management and administrative functions.**

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

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: Courtyard Estates of Sullivan **Report Period Beginning:** 1/1/2009 **Ending:** 12/31/2009

VIII. OWNERSHIP COSTS

A. Purchase price of land 315,335 **Year land was acquired** 2004

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			2008	$ 6,418,133	$ 164,567	39	$ 164,568	$ 1	$ 246,852	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Entrance Sign			2009	5,890	131	15	196	65	196	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)				$ 6,424,023	$ 164,698		$ 164,764	$ 66	$ 247,048	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	$ 336,812	$ 47,932	$ 33,527	(14,405)	10 yrs.	$ 50,213	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 336,812	$ 47,932	$ 33,527	(14,405)		$ 50,213	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	N/A	$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: Courtyard Estates of Sullivan **Report Period Beginning:** 1/1/2009 **Ending:** 2/31/2009

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. **Name of Party Holding Lease:** N/A

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 $** 130

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.** See Schedule 6A

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	U.S. Bank		X	Mortgage	12/7/08	$ 4,579,869	$ 4,458,972	12/8/11	Varies	$ 317,524	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 4,579,869	$ 4,458,972			$ 317,524	7
	B. Non-Facility Related										
8					/ /		Amortization Exp.	/ /		8,261	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 4,579,869	$ 4,458,972			$ 325,785	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.

Courtyard Estates of Sullivan
12/31/2009
Vehicle Rental Expense

Schedule 6A
Section IX Rental Costs- #10

Vehicle	Interest Expense	Purpose
2009 Ford E150 Van	4,308	Patient Transportation

Facility Name: Courtyard Estates of Sullivan **Report Period Beginning:** 1/1/2009 **Ending:** 12/31/2009

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2009 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (3,034,000)	$ (3,034,000)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	75,880	75,880	3
4	Supply Inventory (priced N/A)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,819	17,819	6
7	Other Prepaid Expenses	2,414	2,414	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,937,887)	$ (2,937,887)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	321,225	315,335	13
14	Buildings, at Historical Cost	6,418,133	6,418,133	14
15	Leasehold Improvements, at Historical Cost		5,890	15
16	Equipment, at Historical Cost	336,812	336,812	16
17	Accumulated Depreciation (book methods)	(258,833)	(297,196)	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 (**Loan Costs**	15,834	15,834	22
23	Other(specify): **Condo/Duplexes for Sale**	369,854	369,854	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,203,025	$ 7,164,662	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,265,138	$ 4,226,775	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,840	$ 54,840	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,996	9,996	30
31	Accrued Taxes Payable	825	825	31
32	Accrued Interest Payable	126,344	126,344	32
33	Deferred Compensation	31,482	31,482	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	**Payroll Withholdings**	17,647	17,647	35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 241,134	$ 241,134	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,458,972	4,458,972	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	**Security Deposits**	9,775	9,775	42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 4,468,747	$ 4,468,747	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 4,709,881	$ 4,709,881	45
46	**TOTAL EQUITY**	$ (444,743)	$ (483,106)	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 4,265,138	$ 4,226,775	47

***(See instructions.)**

Facility Name: Courtyard Estates of Sullivan **Report Period Beginning: 1/1/2009 Ending: 12/31/2009**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 799,130	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 799,130	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	94	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 94	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$	14
	D. Other Revenue (specify):		
15	**Telephone, Television & Radio**	1,710	15
16	**Miscellaneous Revenue**	6,587	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 8,297	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 807,521	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	193,147	19
20	Health Care/ Personal Care	130,780	20
21	General Administration	86,093	21
	B. Capital Expense		
22	Ownership	663,441	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)**	$ 1,073,461	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (265,940)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (265,940)	31