

		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: Legacy Estates of Monmouth

Address: 1200 West Broadway Monmouth 61462
Number City Zip Code

County: Warren

Telephone Number: (309) 734-0909 Fax # (309) 734-0910

Federal Employer ID Number: 30-0174076

Date Current Owners were Certified: 8/16/2007

Type of Ownership:

<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 type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 Legacy Estates of Monmouth

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	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	59	Single Unit Apartment	59	21,535	1
2		Double Unit Apartment			2
3		Other			3
4	59	TOTALS	59	21,535	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	8,423	9,799		18,222	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,423	9,799		18,222	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.62%

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 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)

N/A

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

I. Is your fiscal year identical to your tax year? 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: Legacy Estates of Monmouth

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 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	53,766	91,939		145,705	(5,072)	140,633	1
2	Housekeeping, Laundry and Maintenance	50,344	17,625	24,495	92,464		92,464	2
3	Heat and Other Utilities			68,249	68,249		68,249	3
4	Other (specify):							4
5	TOTAL General Services	104,110	109,564	92,744	306,418	(5,072)	301,346	5
B. Health Care and Programs								
6	Health Care/ Personal Care	281,100	2,196		283,296	(15)	283,281	6
7	Activities and Social Services	3,820	608	110	4,538		4,538	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	284,920	2,804	110	287,834	(15)	287,819	9
C. General Administration								
10	Administrative and Clerical	26,429	3,101	66,160	95,690	23,448	119,138	10
11	Marketing Materials, Promotions and Advertising		384	12,512	12,896	(12,896)		11
12	Employee Benefits and Payroll Taxes			91,677	91,677		91,677	12
13	Insurance-Property, Liability and Malpractice			16,459	16,459		16,459	13
14	Other (specify): Telephone			1,842	1,842		1,842	14
15	TOTAL General Administration	26,429	3,485	188,650	218,564	10,552	229,116	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	415,459	115,853	281,504	812,816	5,465	818,281	16
Capital Expenses								
D. Ownership								
17	Depreciation			124,375	124,375	(13,343)	111,032	17
18	Interest			223,739	223,739		223,739	18
19	Real Estate Taxes			86,318	86,318		86,318	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			925	925		925	21
22	Other (specify): Non-allowable expenses			6,807	6,807	(6,807)		22
23	TOTAL Ownership			442,164	442,164	(20,150)	422,014	23
24	GRAND TOTAL (Sum of lines 16 and 23)	415,459	115,853	723,668	1,254,980	(14,685)	1,240,295	24

Facility Name: Legacy Estates of Monmouth

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	\$ 17.96	1
2	Licensed Practical Nurses	2	14.72	2
3	Certified Nurse Assistants	9	8.67	3
4	Activity Director & Assistants	1	8.84	4
5	Social Service Workers			5
6	Head Cook	1	9.49	6
7	Cook Helpers/Assistants	3	8.15	7
8	Dishwashers			8
9	Maintenance Workers	1	9.40	9
10	Housekeepers	2	7.89	10
11	Laundry			11
12	Managers	1	31.25	12
13	Other Administrative	1	15.54	13
14	Clerical	1	9.71	14
15	Marketing			15
16	Other	1	8.75	16
17	Total (lines 1 thru 16)	24	\$	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

Name	1	City	2
See Attached Schedule 4B			

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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: Petersen Health Care, Inc. If yes, what is the value of those services? \$ 55,000

(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

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: Legacy Estates of Monmouth

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

VIII. OWNERSHIP COSTS

A. Purchase price of land 127,000 Year land was acquired 2005

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	59			2007	\$ 3,548,140	\$ 96,780	39	\$ 90,978	\$ (5,802)	\$ 227,445	1
2				2009	10,000	150	25	200	50	200	2
3											3
4											4
5											5
	Improvement Type										
6		Roof Repair		2008	3,015	201	15	202	1	303	6
7		Wall Remodeling Between Rooms 308 & 310		2008	4,105	274	15	274		411	7
8		Shower Installation		2009	16,200	900	15	540	(360)	540	8
9		Carpet in 3 Halls		2009	18,927	841	15	1,262	421	1,262	9
10		Pool Repair		2009	6,522	36	15	217	181	217	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,606,909	\$ 99,182		\$ 93,673	\$ (5,509)	\$ 230,378	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	\$ 176,350	\$ 25,193	\$ 17,359	(7,834)	10 yrs.	\$ 42,753	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 176,350	\$ 25,193	\$ 17,359	(7,834)		\$ 42,753	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: Legacy Estates of Monmouth

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	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 \$ 925

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	Midwest Bank of Western IL		X	Facility	5/1/09	\$ 2,800,000	\$ 2,761,933	4/30/12	0.0850	\$ 211,692
2					/ /					Amortization Expense
3					/ /			/ /		12,047
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 2,800,000	\$ 2,761,933			\$ 223,739
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 2,800,000	\$ 2,761,933			\$ 223,739

* 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: Legacy Estates of Monmouth

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	\$ (1,160,339)	\$ (1,160,339)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	192,037	192,037	3
4	Supply Inventory (priced: <u>N/A</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,027	21,027	6
7	Other Prepaid Expenses	5,086	5,086	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (942,189)	\$ (942,189)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	142,000	127,000	13
14	Buildings, at Historical Cost	2,762,532	3,558,140	14
15	Leasehold Improvements, at Historical Cost	829,377	48,769	15
16	Equipment, at Historical Cost	176,350	176,350	16
17	Accumulated Depreciation (book methods)	(290,019)	(273,015)	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	4,016	4,016	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,624,256	\$ 3,641,260	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,682,067	\$ 2,699,071	25

*(See instructions.)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 94,819	\$ 94,819	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,715	25,715	30
31	Accrued Taxes Payable	1,613	1,613	31
32	Accrued Interest Payable	87,000	87,000	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Payroll Withholdings	26,027	26,027	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 235,174	\$ 235,174	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,761,933	2,761,933	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Security Deposit	28,200	28,200	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 2,790,133	\$ 2,790,133	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,025,307	\$ 3,025,307	45
46	TOTAL EQUITY	\$ (343,240)	\$ (326,236)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,682,067	\$ 2,699,071	47

Facility Name: Legacy Estates of Monmouth

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.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,538,280	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,538,280	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	5,072	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 5,072	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$	14
D. Other Revenue (specify):			
15	Telephone, Television & Radio	11,913	15
16	Miscellaneous Revenue	28	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 11,941	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,555,293	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	306,418	19
20	Health Care/ Personal Care	287,834	20
21	General Administration	218,564	21
B. Capital Expense			
22	Ownership	442,164	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 1,254,980	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 300,313	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 300,313	31