

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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.

<p>I. Facility ID Number: <u>1000103</u></p> <p>Facility Name: <u>Courtyard Estates of Sullivan</u></p> <hr/> <p>Address: <u>20 Courtyard Boulevard</u> <u>Sullivan</u> <u>61951</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>Moultrie</u></p> <hr/> <p>Telephone Number: <u>(217) 728-4300</u> Fax # <u>(217) 728-2165</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>9/30/08</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact:</p> <p>Name: <u>Larry Templin</u> Telephone Number: <u>(309) 691-8113</u></p> <p>Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2010</u> to <u>12/31/2010</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.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;">(Type or Print Name) <u>Mark B. Petersen</u></td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;">(Title) <u>Chief Executive Officer</u></td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;">(Print Name and Title) _____</td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;">(Firm Name & Address) _____</td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;">(Telephone) <u>()</u> _____</td> <td style="border: none;">Fax # () _____</td> <td style="border: none;"></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>			Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) <u>()</u> _____	Fax # () _____	
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Facility Name Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	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 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	5,395	7,719		13,114	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,395	7,719		13,114	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 71.86%

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 Non-allowable costs have been eliminated in Schedule IV, Column 5

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: 12/31/2010 Fiscal Year: 12/31/2010

* 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? _____

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: Courtyard Estates of Sullivan

Report Period Beginning:

1/1/2010

Ending: 12/31/2010

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	76,522	65,023		141,545	(558)	140,987	1
2	Housekeeping, Laundry and Maintenance	41,452	12,839	10,392	64,683		64,683	2
3	Heat and Other Utilities			61,142	61,142		61,142	3
4	Other (specify):							4
5	TOTAL General Services	117,974	77,862	71,534	267,370	(558)	266,812	5
B. Health Care and Programs								
6	Health Care/ Personal Care	170,068	427	131	170,626		170,626	6
7	Activities and Social Services	1,571	83	183	1,837		1,837	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	171,639	510	314	172,463		172,463	9
C. General Administration								
10	Administrative and Clerical	19,869	1,427	123,362	144,658	(48,644)	96,014	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			51,016	51,016		51,016	12
13	Insurance-Property, Liability and Malpractice			7,884	7,884		7,884	13
14	Other (specify):							14
15	TOTAL General Administration	19,869	1,427	182,262	203,558	(48,644)	154,914	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	309,482	79,799	254,110	643,391	(49,202)	594,189	16
Capital Expenses								
D. Ownership								
17	Depreciation			213,076	213,076	(14,433)	198,643	17
18	Interest			387,181	387,181		387,181	18
19	Real Estate Taxes			89,058	89,058		89,058	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,674	6,674		6,674	21
22	Other (specify):		2,427	23,950	26,377	(26,377)		22
23	TOTAL Ownership		2,427	719,939	722,366	(40,810)	681,556	23
24	GRAND TOTAL (Sum of lines 16 and 23)	309,482	82,226	974,049	1,365,757	(90,012)	1,275,745	24

Facility Name: Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2010

Ending:

12/31/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 19.54	1
2	Licensed Practical Nurses	1	18.52	2
3	Certified Nurse Assistants	5	9.99	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	10.45	6
7	Cook Helpers/Assistants	3	9.55	7
8	Dishwashers			8
9	Maintenance Workers	1	13.44	9
10	Housekeepers	1	8.00	10
11	Laundry			11
12	Managers	1	30.28	12
13	Other Administrative			13
14	Clerical	1	10.47	14
15	Marketing			15
16	Other	1	10.82	16
17	Total (lines 1 thru 16)	16	\$	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? \$ 108,000

(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: Courtyard Estates of Sullivan

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

VIII. OWNERSHIP COSTSA. 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	164,568	39	164,568	\$	\$ 411,420	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Entrance Sign		2009		5,890	393	15	393		589	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	\$ 164,961		\$ 164,961	\$	\$ 412,009	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	48,115	33,682	(14,433)	10 yrs.	83,895	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 336,812	\$ 48,115	\$ 33,682	(14,433)		\$ 83,895	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: 1/1/2010

Ending: 2/31/2010

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 \$ -

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		3	4	6		7	8	9						
			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		U.S. Bank		X	Mortgage	12/7/08	4,579,869	4,317,957	12/8/11	Varies	378,920	1					
2												2					
3												3					
		Working Capital															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		TOTAL Facility Related					\$ 4,579,869	\$ 4,317,957			\$ 378,920	7					
		B. Non-Facility Related															
8						/ /		Amortization Exp.	/ /		8,261	8					
9						/ /			/ /			9					
10		TOTALS (lines 7, 8 and 9)					\$ 4,579,869	\$ 4,317,957			\$ 387,181	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

12/31/2010

Vehicle Rental Expense

Schedule 6A

Section IX Rental Costs- #10

Vehicle	Rent Expense	Purpose
2009 Ford E150 Van	6,462	Patient Transportation

Facility Name: Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2010

Ending:

12/31/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 300	\$ 300	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	3,437	3,437	3
4	Supply Inventory (priced at <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,206	12,206	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)	\$ 18,357	\$ 18,357	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)	(471,910)	(495,904)	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)	377,427	377,427	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,981,687	\$ 6,957,693	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,000,044	\$ 6,976,050	25

*(See instructions.)

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,222,136	\$ 3,222,136	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,276	18,276	30
31	Accrued Taxes Payable	3,410	3,410	31
32	Accrued Interest Payable	107,340	107,340	32
33	Deferred Compensation	30,584	30,584	33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Payroll Withholdings	11,835	11,835	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 3,393,581	\$ 3,393,581	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,317,957	4,317,957	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Security Deposits	13,475	13,475	42
43	Due to Related Parties	587	587	43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,332,019	\$ 4,332,019	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,725,600	\$ 7,725,600	45
46	TOTAL EQUITY	\$ (725,556)	\$ (749,550)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,000,044	\$ 6,976,050	47

Facility Name: Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2010

Ending:

12/31/2010

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	\$ 1,079,929	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,079,929	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	558	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 558	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	Cable Television Revenue	4,560	15
16	Miscellaneous Revenue	(103)	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 4,457	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,084,944	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	267,370	19
20	Health Care/ Personal Care	172,463	20
21	General Administration	203,558	21
B. Capital Expense			
22	Ownership	722,366	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)	\$ 1,365,757	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (280,813)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (280,813)	31