

		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.

**I. Facility ID Number:** 1000084

**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:** \_\_\_\_\_

**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 _____	

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Mark B. Petersen</u>	
	(Title) <u>Chief Executive Officer</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( _____ ) _____ Fax # ( _____ ) _____	

**In the event there are further questions about this report, please contact:**

**Name:** Larry Templin **Telephone Number:** (309) 691-8113  
**Email Address:** \_\_\_\_\_

**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: 1/1/2010 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	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 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	8,952	11,542		20,494	5
6	Double Unit					6
7	Other					7
8	TOTALS	8,952	11,542		20,494	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.17%

**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: Legacy Estates of Monmouth

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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	65,950	103,669		169,619	(4,486)	165,133	1
2	Housekeeping, Laundry and Maintenance	70,026	25,970	18,354	114,350		114,350	2
3	Heat and Other Utilities			61,775	61,775		61,775	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>135,976</b>	<b>129,639</b>	<b>80,129</b>	<b>345,744</b>	<b>(4,486)</b>	<b>341,258</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	301,250	1,569		302,819		302,819	6
7	Activities and Social Services	18,741	80	367	19,188		19,188	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>319,991</b>	<b>1,649</b>	<b>367</b>	<b>322,007</b>		<b>322,007</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	17,972	1,701	126,172	145,845	(62,508)	83,337	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			95,359	95,359		95,359	12
13	Insurance-Property, Liability and Malpractice			9,023	9,023		9,023	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>17,972</b>	<b>1,701</b>	<b>230,554</b>	<b>250,227</b>	<b>(62,508)</b>	<b>187,719</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>473,939</b>	<b>132,989</b>	<b>311,050</b>	<b>917,978</b>	<b>(66,994)</b>	<b>850,984</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			126,458	126,458	(13,667)	112,791	17
18	Interest			197,310	197,310		197,310	18
19	Real Estate Taxes			52,496	52,496		52,496	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			885	885		885	21
22	Other (specify):		160	8,435	8,595	(8,595)		22
23	<b>TOTAL Ownership</b>		<b>160</b>	<b>385,584</b>	<b>385,744</b>	<b>(22,262)</b>	<b>363,482</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>473,939</b>	<b>133,149</b>	<b>696,634</b>	<b>1,303,722</b>	<b>(89,256)</b>	<b>1,214,466</b>	<b>24</b>

Facility Name: Legacy Estates of Monmouth

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	2	16.94	1
2	Licensed Practical Nurses	2	15.01	2
3	Certified Nurse Assistants	10	8.71	3
4	Activity Director & Assistants	1	9.19	4
5	Social Service Workers			5
6	Head Cook	1	9.57	6
7	Cook Helpers/Assistants	3	8.09	7
8	Dishwashers			8
9	Maintenance Workers	1	15.57	9
10	Housekeepers	2	8.16	10
11	Laundry			11
12	Managers	1	24.29	12
13	Other Administrative			13
14	Clerical	1	9.78	14
15	Marketing			15
16	Other	1	8.94	16
17	<b>Total (lines 1 thru 16)</b>	<b>25</b>	<b>\$</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	N/A	\$ 1
2		2
<b>Total</b>		<b>\$ 3</b>

**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? \$ 113,000

(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:

1/1/2010

Ending:

12/31/2010

**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	96,849	39	90,978	\$ (5,871)	\$ 318,423	1
2				2009	10,000	401	25	400	(1)	600	2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Roof Repair		2008	3,015	201	15	201		504	6
7		Wall Remodeling between Rooms 308 & 310		2008	4,105	274	15	274		685	7
8		Shower Installation		2009	16,200	1,080	15	1,080		1,620	8
9		Carpet in 3 Halls		2009	18,927	1,262	15	1,262		2,524	9
10		Pool Repair		2009	6,522	435	15	435		652	10
11		Curb Replacement		2010	8,800	98	15	293	195	293	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,615,709	\$ 100,600		\$ 94,923	\$ (5,677)	\$ 325,301	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	\$ 181,009	25,858	17,868	(7,990)	10 yrs.	60,505	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 181,009	\$ 25,858	\$ 17,868	(7,990)		\$ 60,505	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: 1/1/2010

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	<b>TOTAL</b>				\$			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**

	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			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	Midwest Bank of Western IL		X	Mortgage	5/1/09	2,800,000	2,692,662	4/30/12	0.0850	193,294	1					
2											2					
3											3					
	<b>Working Capital</b>															
4					/ /			/ /			4					
5					/ /			/ /			5					
6					/ /			/ /			6					
7	<b>TOTAL Facility Related</b>					\$ 2,800,000	\$ 2,692,662			\$ 193,294	7					
	<b>B. Non-Facility Related</b>															
8					/ /		Amortization Exp.	/ /		4,016	8					
9					/ /			/ /			9					
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,800,000	\$ 2,692,662			\$ 197,310	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.

Facility Name: Legacy Estates of Monmouth

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 575	\$ 575	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	58,256	58,256	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,403	14,403	6
7	Other Prepaid Expenses	5,086	5,086	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 78,320	\$ 78,320	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,800	127,000	13
14	Buildings, at Historical Cost	2,762,532	3,558,140	14
15	Leasehold Improvements, at Historical Cost	829,377	57,569	15
16	Equipment, at Historical Cost	181,009	181,009	16
17	Accumulated Depreciation (book methods)	(416,477)	(385,806)	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 ( <b>Loan Costs</b> )			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,507,241	\$ 3,537,912	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,585,561	\$ 3,616,232	25

\*(See instructions.)

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 645,413	\$ 645,413	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,373	26,373	30
31	Accrued Taxes Payable	6,862	6,862	31
32	Accrued Interest Payable	69,530	69,530	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
<b>Other Current Liabilities(specify):</b>				
35	<b>Payroll Withholdings</b>	15,943	15,943	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 764,121	\$ 764,121	37
<b>D. Long-Term Liabilities</b>				
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,692,662	2,692,662	39
40	Bonds Payable			40
41	Deferred Compensation			41
<b>Other Long-Term Liabilities(specify):</b>				
42	<b>Security Deposits</b>	31,700	31,700	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 2,724,362	\$ 2,724,362	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,488,483	\$ 3,488,483	45
46	<b>TOTAL EQUITY</b>	\$ 97,078	\$ 127,749	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 3,585,561	\$ 3,616,232	47

Facility Name: Legacy Estates of Monmouth

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	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,726,360	1
2	Discounts and Allowances		2
<b>SUBTOTAL Resident Care</b>			
3	(line 1 minus line 2)	\$ 1,726,360	3
<b>B. Other Operating Revenue</b>			
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	4,486	9
10	Laundry		10
<b>SUBTOTAL OTHER OPERATING REVENUE</b>			
11	(sum of lines 4 thru 10)	\$ 4,486	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
<b>SUBTOTAL Non-Operating Revenue</b>			
14	(sum of lines 12 and 13)	\$	14
<b>D. Other Revenue (specify):</b>			
15	Cable Television Revenue	13,175	15
16	Miscellaneous Revenue	20	16
<b>SUBTOTAL Other Revenue</b>			
17	(sum of lines 15 and 16)	\$ 13,195	17
<b>TOTAL REVENUE</b>			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,744,041	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	345,744	19
20	Health Care/ Personal Care	322,007	20
21	General Administration	250,227	21
<b>B. Capital Expense</b>			
22	Ownership	385,744	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
<b>TOTAL EXPENSES</b>			
28	(sum of lines 19 thru 27)	\$ 1,303,722	28
<b>Income Before Income Taxes</b>			
29	(line 18 minus line 28)	\$ 440,319	29
<b>Income Taxes</b>			
30		\$	30
<b>NET INCOME OR LOSS FOR THE YEAR</b>			
31	(line 29 minus line 30)	\$ 440,319	31