

FOR BHF USE					

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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>1000088</u></p> <p>Facility Name: <u>Courtyard Estates of Canton</u></p> <p>Address: <u>160 East Walnut Street</u> <u>Canton</u> <u>61520</u> <small>Number City Zip Code</small></p> <p>County: <u>Fulton</u></p> <p>Telephone Number: (<u>309</u>) <u>647-6400</u> Fax # <u>(309) 647-1419</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>12/7/2007</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: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 691-8113</u> 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>1/1/2012</u> to <u>12/31/2012</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>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:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Mark B. Petersen</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) () _____ Fax # () _____</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) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) () _____ Fax # () _____																																						

Facility Name Courtyard Estates of Canton

Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	51	Single Unit Apartment	51	18,615	1
2		Double Unit Apartment			2
3		Other			3
4	51	TOTALS	51	18,615	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	5,559	10,996		16,555	5
6	Double Unit					6
7	Other					7
8	TOTALS	5,559	10,996		16,555	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 88.93%

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: 12/31/2012 Fiscal Year: 12/31/2012

* 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 Canton

Report Period Beginning:

1/1/2012

Ending: 12/31/2012

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	88,797	94,189		182,986	(566)	182,420	1
2	Housekeeping, Laundry and Maintenance	87,200	20,178	28,659	136,037		136,037	2
3	Heat and Other Utilities			59,910	59,910		59,910	3
4	Other (specify):							4
5	TOTAL General Services	175,997	114,367	88,569	378,933	(566)	378,367	5
B. Health Care and Programs								
6	Health Care/ Personal Care	138,395	(510)		137,885		137,885	6
7	Activities and Social Services	11,428	215		11,643	(2,297)	9,346	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	149,823	(295)		149,528	(2,297)	147,231	9
C. General Administration								
10	Administrative and Clerical	21,489	2,334	82,966	106,789	(11,564)	95,225	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			58,873	58,873		58,873	12
13	Insurance-Property, Liability and Malpractice			15,106	15,106		15,106	13
14	Other (specify): Non-Allowable Expenses		2,322	16,557	18,879	(18,879)		14
15	TOTAL General Administration	21,489	4,656	173,502	199,647	(30,443)	169,204	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	347,309	118,728	262,071	728,108	(33,306)	694,802	16
Capital Expenses								
D. Ownership								
17	Depreciation			212,053	212,053	(13,459)	198,594	17
18	Interest			430,437	430,437	(2,839)	427,598	18
19	Real Estate Taxes			131,628	131,628		131,628	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,901	12,901		12,901	21
22	Other (specify):							22
23	TOTAL Ownership			787,019	787,019	(16,298)	770,721	23
24	GRAND TOTAL (Sum of lines 16 and 23)	347,309	118,728	1,049,090	1,515,127	(49,604)	1,465,523	24

Facility Name: Courtyard Estates of Canton

Report Period Beginning 1/1/2012 Ending: 12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 18.85	1
2	Licensed Practical Nurses	2	15.10	2
3	Certified Nurse Assistants	10	8.88	3
4	Activity Director & Assistants	1	9.53	4
5	Social Service Workers			5
6	Head Cook	1	9.59	6
7	Cook Helpers/Assistants	3	8.29	7
8	Dishwashers			8
9	Maintenance Workers	1	14.92	9
10	Housekeepers	1	8.16	10
11	Laundry			11
12	Managers	1	28.20	12
13	Other Administrative			13
14	Clerical	1	10.00	14
15	Marketing	1	9.43	15
16	Other			16
17	Total (lines 1 thru 16)	23	\$	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? \$ 69,600

(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).

Facility Name: Courtyard Estates of Canton

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VIII. OWNERSHIP COSTS

A. Purchase price of land 51,519 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	51			2007	\$ 6,650,432	\$ 172,535	39	\$ 170,524	\$ (2,011)	\$ 937,881	1
2				2009	4,409	176	25	176		616	2
3											3
4											4
5											5
Improvement Type											
6		Piping Repair		2009	4,428	633	7	633		2,215	6
7		Piping Repair		2011	2,766	395	7	395		593	7
8		Compressor Repair		2012	3,723	266	7	266		266	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,665,758	\$ 174,005		\$ 171,994	\$ (2,011)	\$ 941,571	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	\$ 266,002	\$ 38,048	\$ 26,600	(11,448)	10 yrs.	\$ 140,860	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 266,002	\$ 38,048	\$ 26,600	(11,448)		\$ 140,860	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 Canton

Report Period Beginning: 1/1/2012

Ending: 2/31/2012

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**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Country Bank		X	Facility	6/15/08	4,680,000	4,419,312	5/15/13	0.0769	\$ 347,694	1
2		Colson Services		X	Facility	2/1/10	1,172,000	1,057,496	2/1/30	0.0420	45,405	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 5,852,000	\$ 5,476,808			\$ 393,099	7
		B. Non-Facility Related										
8						/ /		Amort. Expense	/ /		37,338	8
9						/ /		Interest Offset	/ /		-2,839	9
10		TOTALS (lines 7, 8 and 9)					\$ 5,852,000	\$ 5,476,808			\$ 427,598	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: Courtyard Estates of Canton

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>n/a</u>)	137,567	137,567	3
4	Supply Inventory (priced : <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,078	15,078	6
7	Other Prepaid Expenses	2,432	2,432	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposits</u>	4,034	4,034	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 159,611	\$ 159,611	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	53,950	51,519	13
14	Buildings, at Historical Cost	6,654,841	6,654,841	14
15	Leasehold Improvements, at Historical Cost	10,917	10,917	15
16	Equipment, at Historical Cost	266,002	266,002	16
17	Accumulated Depreciation (book methods)	(1,065,761)	(1,082,431)	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 (<u>Loan Costs</u>)	70,520	70,520	22
23	Other(specify): <u>Prepaid Mgmt. Fees</u>	1,047	1,047	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,991,516	\$ 5,972,415	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,151,127	\$ 6,132,026	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,496,037	\$ 2,496,037	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,942	18,942	30
31	Accrued Taxes Payable	140,726	140,726	31
32	Accrued Interest Payable	21,480	21,480	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Payroll Withholdings</u>	17,453	17,453	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 2,694,638	\$ 2,694,638	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,476,808	5,476,808	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Security Deposit</u>	20,800	20,800	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,497,608	\$ 5,497,608	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,192,246	\$ 8,192,246	45
46	TOTAL EQUITY	\$ (2,041,119)	\$ (2,060,220)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,151,127	\$ 6,132,026	47

*(See instructions.)

Facility Name: Courtyard Estates of Canton

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

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	\$ 1,500,492	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,500,492	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	566	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 566	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,839	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,839	14
D. Other Revenue (specify):			
15	Cable Television Revenue	7,995	15
16	Transportation and Miscellaneous Income	2,911	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 10,906	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,514,803	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	378,933	19
20	Health Care/ Personal Care	149,528	20
21	General Administration	199,647	21
B. Capital Expense			
22	Ownership	787,019	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)	\$ 1,515,127	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (324)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (324)	31

