

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2015  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2015)**

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><b>I. Facility ID Number:</b> <u>1000103</u></p> <p><b>Facility Name:</b> <u>Courtyard Estates of Sullivan</u></p> <p><b>Address:</b> <u>20 Courtyard Blvd</u> <u>Sullivan</u> <u>61951</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Moultrie</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>728-4300</u> Fax # <u>217 728-2165</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>9/30/08</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309) 691-8113</u>  <b>Email Address:</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2015</u> to <u>12/31/2015</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%"> <tr> <td style="width:20%; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td>                 (Signed) _____                  (Type or Print Name) <u>Mark Petersen</u>                  (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> <b>Paid Preparer</b> </td> <td>                 (Signed) _____                  (Date) _____                  (Print Name and Title) _____                  (Firm Name &amp; Address) _____                  (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>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Mark Petersen</u> (Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(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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Facility Name Courtyard Estates of Sullivn

Report Period Beginning: 1/1/2015 Ending: 12/31/2015

**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	7,092	9,719		16,811	5
6	Double Unit					6
7	Other					7
8	TOTALS	7,092	9,719		16,811	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.12%

**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)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

\* 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 Sullivn

Report Period Beginning:

1/1/2015

Ending: 12/31/2015

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	126,612	97,474		224,086	(2,132)	221,954	1
2	Housekeeping, Laundry and Maintenance	55,180	20,057	37,323	112,560		112,560	2
3	Heat and Other Utilities			63,700	63,700		63,700	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	181,792	117,531	101,023	400,346	(2,132)	398,214	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	222,035	863		222,898	(796)	222,102	6
7	Activities and Social Services	2,685	349	18,380	21,414		21,414	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	224,720	1,212	18,380	244,312	(796)	243,516	9
<b>C. General Administration</b>								
10	Administrative and Clerical	23,264	777	169,082	193,123	(83,060)	110,063	10
11	Marketing Materials, Promotions and Advertising		1,953		1,953	(1,953)		11
12	Employee Benefits and Payroll Taxes			86,050	86,050		86,050	12
13	Insurance-Property, Liability and Malpractice			14,659	14,659		14,659	13
14	Other (specify):			24,467	24,467	(24,467)		14
15	<b>TOTAL General Administration</b>	23,264	2,730	294,258	320,252	(109,480)	210,772	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	429,776	121,473	413,661	964,910	(112,408)	852,502	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			202,207	202,207	12,378	214,585	17
18	Interest			142,743	142,743		142,743	18
19	Real Estate Taxes			135,879	135,879		135,879	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			7,604	7,604		7,604	21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			488,433	488,433	12,378	500,811	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	429,776	121,473	902,094	1,453,343	(100,030)	1,353,313	24

Facility Name: Courtyard Estates of Sullivn

Report Period Beginning 1/1/2015 Ending: 12/31/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 19.59	1
2	Licensed Practical Nurses	1	17.75	2
3	Certified Nurse Assistants	7	10.76	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	12.43	6
7	Cook Helpers/Assistants	5	9.69	7
8	Dishwashers			8
9	Maintenance Workers	1	13.33	9
10	Housekeepers	1	13.20	10
11	Laundry			11
12	Managers	1	28.37	12
13	Other Administrative			13
14	Clerical	1	11.18	14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>19</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>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 4A			

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 Management, Inc. If yes, what is the value of those services? \$ 142,000

(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 Sullivn

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

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	\$	\$ 1,234,260	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Painting & Remodeling in Water Damaged Areas		2014	15,348	1,023	15	1,023		1,876	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)				\$ 6,433,481	\$ 165,591		\$ 165,591	\$	\$ 1,236,136	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	\$ 342,961	\$ 36,616	\$ 48,994	12,378	7 yrs.	\$ 282,051	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 342,961	\$ 36,616	\$ 48,994	12,378		\$ 282,051	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 Sullivn

Report Period Beginning: 1/1/2015

Ending: 2/31/2015

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

1. Name of Party Holding Lease: \_\_\_\_\_

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 \$ 7,604

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			
	<b>A. Directly Facility Related</b>									
	<b>Long-Term</b>									
1	Ist Merit		X	Mortgage	2/1/12	\$ 3,704,700	\$ 3,291,801	1/31/17	Varies	\$ 142,743
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 3,704,700	\$ 3,291,801			\$ 142,743
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 3,704,700	\$ 3,291,801			\$ 142,743

\* 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 Sullivan

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (3,206,036)	\$ (3,206,036)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	159,523	159,523	3
4	Supply Inventory (priced : <u>Cost</u> )	2,414	2,414	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,399	16,399	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposits</u>	225	225	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (3,027,475)	\$ (3,027,475)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	315,335	315,335	13
14	Buildings, at Historical Cost	6,418,133	6,418,133	14
15	Leasehold Improvements, at Historical Cost	15,348	15,348	15
16	Equipment, at Historical Cost	342,961	342,961	16
17	Accumulated Depreciation (book methods)	(1,525,179)	(1,518,187)	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>Condo/Duplexes</u> )	184,927	184,927	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,751,525	\$ 5,758,517	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,724,050	\$ 2,731,042	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 9,429	\$ 9,429	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,137	22,137	30
31	Accrued Taxes Payable	150,359	150,359	31
32	Accrued Interest Payable	13,193	13,193	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<u>Payroll Withholdings</u>	62,939	62,939	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 258,057	\$ 258,057	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	3,291,801	3,291,801	39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<u>Security Deposit</u>	8,800	8,800	42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 3,300,601	\$ 3,300,601	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,558,658	\$ 3,558,658	45
46	<b>TOTAL EQUITY</b>	\$ (834,608)	\$ (827,616)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,724,050	\$ 2,731,042	47

\*(See instructions.)

Facility Name: Courtyard Estates of Sullivn

Report Period Beginning: 1/1/2015

Ending:

12/31/2015

**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	\$ 1,414,124	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 1,414,124</b>	<b>3</b>
<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	2,132	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$ 2,132</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	Cable TV Revenue	5,835	15
16	Transportation and Misc. Income	2,606	16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 8,441</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 1,424,697</b>	<b>18</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	400,346	19
20	Health Care/ Personal Care	244,312	20
21	General Administration	320,252	21
<b>B. Capital Expense</b>			
22	Ownership	488,433	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,453,343</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ (28,646)</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ (28,646)</b>	<b>31</b>