FOR BHF USE

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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: 1000103

Facility Name: Courtyard Estates of Sullivn

Address: 20 Courtyard Blvd (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4300 **Fax #** 217 728-2165

Federal Employer ID Number:

Date Current Owners were Certified: 9/30/08

Type of Ownership:

	VOLUNTARY, NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 691-8113
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 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: Courtyard Estates of Sullivn — Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units: N/A

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,658	11,065		17,723	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,658	11,065		17,723	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.11%

D. Indicate the number of paid bed-hold days the SLF had during this year _____ Also, indicate the number of unpaid bed-hold days the SLF had during this year. _____ (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 [X] NO [ ]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

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 [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 12/31/18 Fiscal Year: 12/31/18
* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

Facility Name: Courtyard Estates of Sullivn **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	147,313	106,580		253,893	(3,557)	250,336	1
2	Housekeeping, Laundry and Maintenance	77,555	14,956	25,828	118,339		118,339	2
3	Heat and Other Utilities			62,646	62,646		62,646	3
4	Other (specify):							4
5	**TOTAL General Services**	224,868	121,536	88,474	434,878	(3,557)	431,321	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	247,813	(252)	734	248,295	(3,615)	244,680	6
7	Activities and Social Services	45	623	17,400	18,068		18,068	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	247,858	371	18,134	266,363	(3,615)	262,748	9
	C. General Administration							
10	Administrative and Clerical	31,350	439	182,570	214,359	(89,336)	125,023	10
11	Marketing Materials, Promotions and Advertising		2,717		2,717	(2,717)		11
12	Employee Benefits and Payroll Taxes			60,373	60,373		60,373	12
13	Insurance-Property, Liability and Malpractice			15,849	15,849		15,849	13
14	Other (specify):			34,924	34,924	(34,924)		14
15	**TOTAL General Administration**	31,350	3,156	293,716	328,222	(126,977)	201,245	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	504,076	125,063	400,324	1,029,463	(134,149)	895,314	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			166,989	166,989	(1,156)	165,833	17
18	Interest							18
19	Real Estate Taxes			177,081	177,081		177,081	19
20	Rent -- Facility and Grounds			119,334	119,334		119,334	20
21	Rent -- Equipment							21
22	Other (specify):			2,142	2,142		2,142	22
23	**TOTAL Ownership**			465,546	465,546	(1,156)	464,390	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	504,076	125,063	865,870	1,495,009	(135,305)	1,359,704	24

Facility Name: Courtyard Estates of Sullivn Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		$	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
See Attached Schedule 4A				

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES [X] NO [ ]
Name of related entity: Petersen Health Care Management, Inc. If yes, what is the value of those services? $ 152,200
(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 [X]
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: 1/1/2018 Ending: 12/31/2018

VIII. OWNERSHIP COSTS

A. 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	$ 164,567	39	164,567	$	$ 1,727,963	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Painting & Remodeling in Water Damaged Areas			2014	15,348	1,023	15	1,024	1	4,946	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	$ 165,590		$ 165,591	$ 1	$ 1,732,909	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	$ 348,604	1,399	242	(1,157)	7 yrs.	$ 345,455	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 348,604	$ 1,399	$ 242	(1,157)		$ 345,455	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		$	$	$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$	$	$	24

Facility Name: Courtyard Estates of Sullivn Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [X] NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 [X] 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 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related Long-Term										
1	Bank Leumi		X	Mortgage	5/1/16	3,200,000	$ 2,737,250	4/30/41	Varies	$ 177,081	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 3,200,000	$ 2,737,250			$ 177,081	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 3,200,000	$ 2,737,250			$ 177,081	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 Sullivn **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 550	$ 550	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,783)	346,156	346,156	3
4	Supply Inventory (priced at)	2,414	2,414	4
5	Short-Term Investments			5
6	Prepaid Insurance	9,843	9,843	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 358,963	$ 358,963	10
	B. Long-Term Assets			
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	348,604	348,604	16
17	Accumulated Depreciation (book methods)	(2,025,449)	(2,078,364)	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 (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,071,971	$ 5,019,056	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,430,934	$ 5,378,019	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,851	$ 87,851	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,878	23,878	30
31	Accrued Taxes Payable	253,624	253,624	31
32	Accrued Interest Payable	15,358	15,358	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Payroll Withholdings	146,147	146,147	35
36	Accrued Management Fees	106,791	106,791	36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 633,649	$ 633,649	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,737,250	2,737,250	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Security Deposits	15,300	15,300	42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 2,752,550	$ 2,752,550	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 3,386,199	$ 3,386,199	45
46	**TOTAL EQUITY**	$ 2,044,735	$ 1,991,820	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,430,934	$ 5,378,019	47

***(See instructions.)**

Facility Name: Courtyard Estates of Sullivn **Report Period Beginning: 1/1/2018 Ending: 12/31/2018**

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,573,114	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,573,114	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	3,557	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 3,557	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$	14
	D. Other Revenue (specify):		
15	**Cable TV Revenue**	7,967	15
16	**Miscellaneous Income**	3,651	16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 11,618	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,588,289	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	434,878	19
20	Health Care/ Personal Care	266,363	20
21	General Administration	328,222	21
	B. Capital Expense		
22	Ownership	465,546	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)**	$ 1,495,009	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 93,280	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 93,280	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 635,155	32
33	Private Pay - Net Inpatient Revenue	937,959	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,573,114	37