

		FOR BHF USE			

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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> <p>Address: <u>20 Courtyard Boulevard</u> <u>Sullivan</u> <u>61951</u> <small>Number City Zip Code</small></p> <p>County: <u>Moultrie</u></p> <p>Telephone Number: (<u>217</u>) <u>728-4300</u> Fax # (<u>217</u>) <u>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%"> <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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</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>1/1/2011</u> to <u>12/31/2011</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;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & 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>	Officer or Administrator of Provider	(Signed) _____ (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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Facility Name Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	6,691	8,482		15,173	5
6	Double Unit					6
7	Other					7
8	TOTALS	6,691	8,482		15,173	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.14%

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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:

1/1/2011

Ending: 12/31/2011

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	82,236	79,432		161,668	(2,854)	158,814	1
2	Housekeeping, Laundry and Maintenance	44,381	12,275	8,392	65,048		65,048	2
3	Heat and Other Utilities			66,540	66,540		66,540	3
4	Other (specify):							4
5	TOTAL General Services	126,617	91,707	74,932	293,256	(2,854)	290,402	5
B. Health Care and Programs								
6	Health Care/ Personal Care	165,311	1,195		166,506		166,506	6
7	Activities and Social Services		521	858	1,379		1,379	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	165,311	1,716	858	167,885		167,885	9
C. General Administration								
10	Administrative and Clerical	21,797	3,060	56,244	81,101	10,860	91,961	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			85,865	85,865		85,865	12
13	Insurance-Property, Liability and Malpractice			7,289	7,289		7,289	13
14	Other (specify): Nonallowable costs		1,110	32,410	33,520	(33,520)		14
15	TOTAL General Administration	21,797	4,170	181,808	207,775	(22,660)	185,115	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	313,725	97,593	257,598	668,916	(25,514)	643,402	16
Capital Expenses								
D. Ownership								
17	Depreciation			213,076	213,076	(14,433)	198,643	17
18	Interest			346,701	346,701	(1,750)	344,951	18
19	Real Estate Taxes			118,994	118,994		118,994	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,695	6,695		6,695	21
22	Other (specify):							22
23	TOTAL Ownership			685,466	685,466	(16,183)	669,283	23
24	GRAND TOTAL (Sum of lines 16 and 23)	313,725	97,593	943,064	1,354,382	(41,697)	1,312,685	24

Facility Name: Courtyard Estates of Sullivan

Report Period Beginning 1/1/2011 Ending: 12/31/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 18.03	1
2	Licensed Practical Nurses	1	18.20	2
3	Certified Nurse Assistants	5	9.89	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	11.14	6
7	Cook Helpers/Assistants	3	8.88	7
8	Dishwashers			8
9	Maintenance Workers	1	13.52	9
10	Housekeepers	1	8.32	10
11	Laundry			11
12	Managers	1	28.30	12
13	Other Administrative			13
14	Clerical	1	10.75	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	15	\$	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? \$ 48,000

(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:

1/1/2011

Ending:

12/31/2011

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	164,568	39	164,568	\$	\$ 575,988	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Entrance Sign		2009	5,890	393	15	393		982	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	\$	\$ 576,970	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	48,116	33,682	(14,434)	10 yrs.	117,577	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 336,812	\$ 48,116	\$ 33,682	(14,434)		\$ 117,577	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: 1/1/2011

Ending: 2/31/2011

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	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			
	A. Directly Facility Related									
	Long-Term									
1	U.S. Bank		X	Mortgage	12/7/08	4,579,869	4,166,748	12/8/11	Varies	339,128
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 4,579,869	\$ 4,166,748			\$ 339,128
	B. Non-Facility Related									
8					/ /		Amortization Exp.	/ /		7,573
9					/ /		Easement Payment	/ /		-1,750
10	TOTALS (lines 7, 8 and 9)					\$ 4,579,869	\$ 4,166,748			\$ 344,951

* 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
12/31/2011
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: 1/1/2011

Ending: 12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(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>)	124,902	124,902	3
4	Supply Inventory (priced : <u>Cost</u>)	2,414	2,414	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,904	13,904	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)	\$ 141,520	\$ 141,520	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)	(684,985)	(694,547)	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>Condos/Duplexes</u>)	369,854	369,854	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,761,039	\$ 6,751,477	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,902,559	\$ 6,892,997	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,317,056	\$ 3,317,056	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,309	18,309	30
31	Accrued Taxes Payable	116,159	116,159	31
32	Accrued Interest Payable	9,940	9,940	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Payroll Withholdings</u>	20,590	20,590	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 3,482,054	\$ 3,482,054	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,166,748	4,166,748	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Security Deposits</u>	16,175	16,175	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 4,182,923	\$ 4,182,923	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,664,977	\$ 7,664,977	45
46	TOTAL EQUITY	\$ (762,418)	\$ (771,980)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,902,559	\$ 6,892,997	47

*(See instructions.)

Facility Name: Courtyard Estates of Sullivan

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

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	\$ 1,306,945	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,306,945	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	2,854	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 2,854	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 Telvesion Income	5,971	15
16	Miscellaneous Income	1,750	16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 7,721	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,317,520	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	293,256	19
20	Health Care/ Personal Care	167,885	20
21	General Administration	207,775	21
B. Capital Expense			
22	Ownership	685,466	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)	\$ 1,354,382	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (36,862)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (36,862)	31