FOR BHF USE

LL2

Supportive Living Facility

2013

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)

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: 1000108

Facility Name: Maple Point

Address: 1000 Union Drive (Number) Monticello (City) 61856 (Zip Code)

County: Piatt

Telephone Number: 217- 762-2506 **Fax #** 217-762-2507

Federal Employer ID Number:

Date Current Owners were Certified: 12/10/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Margel S. Peddicord, CPA **Telephone Number:** 618-315-6242
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 12/1/12 to 11/30/13 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) 3/31/2014
(Type or Print Name) Gary Coulter
(Title) Executive Director

Paid Preparer

(Signed) See Accountant's Preparation Report (Date)
(Print Name and Title) Margel S. Peddicord, CPA
(Firm Name & Address) Margel S. Peddicord, CPA, 2616 Windcrest Dr. Mt. Vernon, IL 62864
(Telephone) 618) 315-6242 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 Maple Point Report Period Beginning: 12/1/12 Ending: 11/30/13

III. STATISTICAL DATA

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

	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	14	Single Unit Apartment	14	5,110	1
2	16	Double Unit Apartment	16	5,840	2
3		Other			3
4	30	TOTALS	30	10,950	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	1,438	8,862		10,300	5
6	Double Unit					6
7	Other					7
8	TOTALS	1,438	8,862		10,300	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.06%

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 [ ] NO [X]

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)

H. ACCOUNTING BASIS

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

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: ____ **Fiscal Year:** Nov. 30
*** 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?** NA
If no, explain. NA

Facility Name: Maple Point **Report Period Beginning: 12/1/12 Ending: 11/30/13**

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	81,384	82,519	3,320	167,223		167,223	1
2	Housekeeping, Laundry and Maintenance	27,883	10,074	42,466	80,423		80,423	2
3	Heat and Other Utilities			39,359	39,359		39,359	3
4	Other (specify):							4
5	**TOTAL General Services**	109,267	92,593	85,145	287,005		287,005	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	227,780	451	56	228,287		228,287	6
7	Activities and Social Services	14,003	583	18,171	32,757		32,757	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	241,783	1,034	18,227	261,044		261,044	9
	C. General Administration							
10	Administrative and Clerical	45,827	9,384	74,549	129,760		129,760	10
11	Marketing Materials, Promotions and Advertising			1,377	1,377		1,377	11
12	Employee Benefits and Payroll Taxes			85,609	85,609		85,609	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	**TOTAL General Administration**	45,827	9,384	161,535	216,746		216,746	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	396,877	103,011	264,907	764,795		764,795	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			157,651	157,651		157,651	17
18	Interest			128,380	128,380		128,380	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			286,031	286,031		286,031	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	396,877	103,011	550,938	1,050,826		1,050,826	24

Facility Name: Maple Point Report Period Beginning: 12/1/12 Ending: 11/30/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.50	$ 21.98	1
2	Licensed Practical Nurses	0.25	18.81	2
3	Certified Nurse Assistants	7.36	13.53	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.80	13.84	7
8	Dishwashers			8
9	Maintenance Workers	0.77	12.29	9
10	Housekeepers	0.60	10.58	10
11	Laundry			11
12	Managers	1.00	22.69	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13.28	$	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				$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	NA	$	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
Piatt Co. NH		Monticello		Name					

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 [X]
Name of related entity: _____ If yes, what is the value of those services? $ _____
(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: Maple Point **Report Period Beginning: 12/1/12** **Ending: 11/30/13**

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	30		2008	2008	$ 3,768,693	$ 125,351	30	$ 125,351	$	$ 626,819	1
2											2
3											3
4											4
5											5
	Improvement Type										
6				2009	36,739	3,674	10	3,674		16,533	6
7				2008	80,703	9,687	8	9,687		48,435	7
8				2009	28,899	5,446	6	5,446		24,506	8
9				2010	8,783	293	30	293		1,025	9
10				2010	875	88	10	88		308	10
11				2010	2,230	149	15	149		521	11
12				2012	2,897	290	10	290		580	12
13				2012	899	90	10	90		180	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 3,930,718	$ 145,068		$ 145,068	$	$ 718,907	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	$ 138,380	$ 12,583	$	(12,583)		$ 53,851	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 138,380	$ 12,583	$	(12,583)		$ 53,851	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: Maple Point Report Period Beginning: 12/1/12 Ending: 11/30/13

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 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 ☐ 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 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				Mortgage and Bonds	/ /	$	$ 2,855,000	/ /		$ 128,380	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 2,855,000			$ 128,380	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 2,855,000			$ 128,380	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: Maple Point **Report Period Beginning:** 12/1/12 **Ending:** 11/30/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/13 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 556,965	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	107,053		3
4	Supply Inventory (priced at)	14,874		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	854,485		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,533,377	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	88,390		13
14	Buildings, at Historical Cost	3,931,118		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	138,380		16
17	Accumulated Depreciation (book methods)	(772,758)		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)**	$ 3,385,130	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,918,507	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,638	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	5,098		31
32	Accrued Interest Payable	9,261		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Security deposit	31,466		35
36	Other-PCNH	61,834		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 178,297	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,015,000		39
40	Bonds Payable	1,840,000		40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 2,855,000	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 3,033,297	$	45
46	**TOTAL EQUITY**	$ 1,885,210	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 4,918,507	$	47

***(See instructions.)**

Facility Name: Maple Point **Report Period Beginning: 12/1/12 Ending: 11/30/13**

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	$ 1,072,123	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,072,123	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	1,772	8
9	Non-Resident Meals	4,908	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 6,680	11
	C. Non-Operating Revenue		
12	Contributions	84,549	12
13	Interest and Other Investment Income	534	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 85,083	14
	D. Other Revenue (specify):		
15	**Other Income-Insurance**	47,025	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 47,025	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,210,911	18

		2	
	Expenses	**Amount**	
	A. Operating Expenses		
19	General Services	287,005	19
20	Health Care/ Personal Care	261,044	20
21	General Administration	216,746	21
	B. Capital Expense		
22	Ownership	286,031	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)**	$ 1,050,826	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 160,085	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 160,085	31