

		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.

I. Facility ID Number: 1000108

Facility Name: Maple Point

Address: 1000 Union Drive Monticello 61856

Number City Zip Code

County: Piatt

Telephone Number: (217) 762-6665 Fax # 217 762-2507

Federal Employer ID Number:

Date Current Owners were Certified: 12/10/08

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☒	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 12/1/11 to 11/30/12 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)		
	(Title)		
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

Report Period Beginning: 12/1/11 **Ending:** 11/30/12

Date of change in certified units / /

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.

Also, indicate the number of unpaid bed-hold days the SLF had during this year. (Do not include bed-hold days in Section B.)

STATE OF ILLINOIS

Facility Name: Maple Point

Report Period Beginning:

12/1/11

Ending:

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11/30/12

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					5	6	
1	Dietary and Food Purchase	82,043	81,502	3,740	167,286		167,286	1
2	Housekeeping, Laundry and Maintenance	19,753	16,480	15,628	51,861		51,861	2
3	Heat and Other Utilities			44,769	44,769		44,769	3
4	Other (specify):							4
5	TOTAL General Services	101,796	97,982	64,137	263,915		263,915	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	226,443	967		227,410		227,410	6
7	Activities and Social Services	12,991	72	16,233	29,296		29,296	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	239,434	1,039	16,233	256,705		256,705	9
	C. General Administration							
10	Administrative and Clerical	47,229	6,837	82,206	136,272		136,272	10
11	Marketing Materials, Promotions and Advertising			873	873		873	11
12	Employee Benefits and Payroll Taxes			80,416	80,416		80,416	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration	47,229	6,837	163,495	217,560		217,560	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	388,458	105,857	243,865	738,181		738,181	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			156,951	156,951		156,951	17
18	Interest			222,888	222,888		222,888	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			379,839	379,839		379,839	23
24	GRAND TOTAL (Sum of lines 16 and 23)	388,458	105,857	623,704	1,118,019		1,118,019	24

Facility Name: Maple Point

Report Period Beginning 12/1/11 Ending: 11/30/12

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.76	\$ 21.78	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	6.96	13.29	3
4	Activity Director & Assistants	0.52	10.40	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.99	13.19	7
8	Dishwashers			8
9	Maintenance Workers	0.34	12.04	9
10	Housekeepers	0.48	11.34	10
11	Laundry			11
12	Managers	1.05	21.76	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13.10	\$	17

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
Piatt County Nursing Home		Monticello	

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	NA			\$ NA	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

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: If yes, what is the value of 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: Maple Point Report Period Beginning: 12/1/11 Ending: 11/30/12

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	\$ 125,623	30	\$ 125,623		\$ 501,468	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Grounds Landscaping			2009	36,739	3,674	10	3,674		12,859	6
7	Alarm & Nurse Call System			2008	80,703	9,687	8	9,687		38,748	7
8	Window treatments and decorating			2009	28,899	5,446	6	5,446		19,060	8
9	Building improvement			2010	8,783	293	30	293		732	9
10	Landscaping			2010	875	88	10	88		220	10
11	Door Panel			2010	2,230	149	15	149		372	11
12	Patio Awning			2012	2,897	290	10	290		290	12
13	Landscaping trees & shrubs			2012	899	90	10	90		90	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,930,718	\$ 145,340		\$ 145,340		\$ 573,839	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	\$ 131,961	\$ 11,612	\$ 11,612		various	\$ 41,268	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 131,961	\$ 11,612	\$ 11,612			\$ 41,268	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

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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

	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			X	Mortgage & Bonds	/ /	\$	3,035,000	/ /		\$ 222,888	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	3,035,000			\$ 222,888	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	3,035,000			\$ 222,888	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.

STATE OF ILLINOIS

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

Ending:

11/30/12**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/12**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 591,088	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	127,273		3
4	Supply Inventory (priced at)	3,480		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	335,110		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,056,950	\$	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	132,204		16
17	Accumulated Depreciation (book methods)	(615,107)		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)	\$ 3,536,605	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,593,556	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,167	\$	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	8,963		31
32	Accrued Interest Payable	10,248		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Security deposit liability	40,529		35
36	Intercompany PCNH	(170,091)		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ (59,184)	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,115,000		39
40	Bonds Payable	1,920,000		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)	\$ 3,035,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,975,816	\$	45
46	TOTAL EQUITY	\$ 1,617,740	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,593,556	\$	47

*(See instructions.)

Facility Name: Maple Point

Report Period Beginning: 12/1/11

Ending:

11/30/12

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,075,211	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,075,211	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	2,202	8
9	Non-Resident Meals	4,489	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 6,692	11
	C. Non-Operating Revenue		
12	Contributions	80,515	12
13	Interest and Other Investment Income	965	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 81,481	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,163,383	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	263,915	19
20	Health Care/ Personal Care	256,705	20
21	General Administration	217,560	21
	B. Capital Expense		
22	Ownership	379,839	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)	\$ 1,118,019	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 45,364	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 45,364	31

