

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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 DriveMonticello61856

County: Piatt

Telephone Number: (217) 762-2506 Fax # (217) 762-2507

Federal Employer ID Number:

Date Current Owners were Certified: 12/10/2008

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X

County

Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2018 to 11/30/2019 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)

(Type or Print Name) Scott Porter

(Title) Executive Director

Paid Preparer

(Signed)

(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

In the event there are further questions about this report, please contact:

Name: Scott Porter

Telephone Number: (217) 762-2506

Email Address:

HFS 3745C (N-4-05)

IL478-2471

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	14	Single Unit Apartment	14	5,110	1
2	16	Double Unit Apartment	16	5,840	2
3		Other		810	3
4	30	TOTALS	30	11,760	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	1,945	3,088		5,033	5
6	Double Unit	1,371	4,260		5,631	6
7	Other		810		810	7
8	TOTALS	3,316	8,158		11,474	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.57%

D. Indicate the number of paid bed-hold days the SLF had during this year

181 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 27 (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)

None

H. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 11/30/2019 Fiscal Year: 11/30/2019

* 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? N/A
If no, explain. N/A

K. Does the facility have any loans from the Federal Home Loan Bank outstanding?

N/A If yes, did the facility make all of the required payments of interest and principal? N/A
If no, explain. N/A

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? N/A
If no, explain. N/A

STATE OF ILLINOIS

Page 3

Facility Name: Maple Point

Report Period Beginning:

12/01/2018

Ending:

11/30/2019

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	94,992	97,352	2,030	194,375	(7,948)	186,427	1
2	Housekeeping, Laundry and Maintenance	67,542		11,734	79,276		79,276	2
3	Heat and Other Utilities			66,016	66,016	(5,293)	60,723	3
4	Other (specify):							4
5	TOTAL General Services	162,534	97,352	79,780	339,667	(13,241)	326,426	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	256,598	340		256,938		256,938	6
7	Activities and Social Services	37,449	3,061		40,510	(4,440)	36,070	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	294,047	3,401		297,448	(4,440)	293,008	9
	C. General Administration							
10	Administrative and Clerical	49,798	20,829	50,386	121,012	(3,251)	117,761	10
11	Marketing Materials, Promotions and Advertising			1,986	1,986	(624)	1,362	11
12	Employee Benefits and Payroll Taxes			80,537	80,537		80,537	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration	49,798	20,829	132,909	203,535	(3,875)	199,660	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	506,380	121,582	212,689	840,650	(21,556)	819,094	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			155,986	155,986	13,673	169,659	17
18	Interest			51,250	51,250	(435)	50,815	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			577	577		577	21
22	Other (specify):							22
23	TOTAL Ownership			207,814	207,814	13,238	221,052	23
24	GRAND TOTAL (Sum of lines 16 and 23)	506,380	121,582	420,503	1,048,464	(8,318)	1,040,146	24

Facility Name: Maple Point

Report Period Beginning 12/01/2018 Ending: 11/30/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.02	\$ 21.06	1
2	Licensed Practical Nurses	1.00	25.12	2
3	Certified Nurse Assistants	6.79	16.61	3
4	Activity Director & Assistants	1.34	14.83	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.64	14.97	7
8	Dishwashers			8
9	Maintenance Workers	0.67	13.30	9
10	Housekeepers	0.93	11.47	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.04	22.91	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	14.43	\$ 17.53	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
Piatt County	Monticello

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
None		

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? \$

(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).

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

Facility Name: Maple Point

Report Period Beginning:

12/01/2018

Ending:

11/30/2019

VIII. OWNERSHIP COSTS

A. Purchase price of land 88,390 Year land was acquired 2008

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	\$ 125,351	\$ (272)	\$ 1,378,925	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Various		2008		80,703	1	20		(1)	80,703	6
7	Various		2009		65,638		20	1,836	1,836	65,638	7
8	Various		2010		11,888		20	530	530	5,034	8
9	Improvements		2012		2,897	193	20	290	97	2,320	9
10	Improvements		2012		899		20	90	90	720	10
11	Door		2014		2,819	141	20	141		846	11
12	Call Lights		2015		39,736	2,649	20	1,987	(662)	9,934	12
13	Security Cameras		2016		6,500	1,300	20	325	(975)	1,300	13
14	HVAC Repairs		2016		4,849	485	20	242	(243)	969	14
15	Dining Room Carpet		2016		6,160	616	20	308	(308)	1,232	15
16	Improvements to Facility		2017		2,658	266	20	133	(133)	399	16
17	TOTAL (lines 1 thru 16)				\$ 3,993,440	\$ 131,274		\$ 131,233	\$ (41)	\$ 1,548,020	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	\$ 270,788	\$ 20,336	\$ 26,134	5,798		\$ 174,055	18
19	Vehicles	57,450	3,830	11,490	7,660	5	45,960	19
20	TOTAL (lines 18 and 19)		\$ 328,238	\$ 24,166	\$ 37,624		\$ 220,015	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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 3,993,440	\$ 131,274		\$ 131,233	\$ (41)	\$ 1,548,020	1
2	New Speaker System	2017	2,949		20	147	147	442	2
3	Water Heater	2019	13,096	546	10	655	109	655	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,009,485	\$ 131,820		\$ 132,035	\$ 215	\$ 1,549,117	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		☐ YES ☒ NO
3	Original Building			/ /	\$			3	9. Rental amount for movable equipment \$ 577
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 \$ 577

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	Debt Certificates		X		/ /	\$	626,000	/ /		\$ 51,250	1
2	Revenue Bonds		X		/ /		1,517,750	/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	2,143,750			\$ 51,250	7
	B. Non-Facility Related										
8					/ /			Interest Income		(435)	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	2,143,750			\$ 50,815	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

Page 7

Facility Name: **Maple Point**Report Period Beginning: **12/01/2018**

Ending:

11/30/2019**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/2019**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 452,784	\$ 452,784	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	44,500	44,500	3
4	Supply Inventory (priced at)	7,633	7,633	4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 504,918	\$ 504,918	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	88,390	88,390	13
14	Buildings, at Historical Cost	3,768,693	3,768,693	14
15	Leasehold Improvements, at Historical Cost	236,827	240,792	15
16	Equipment, at Historical Cost	318,571	328,238	16
17	Accumulated Depreciation (book methods)	(1,746,679)	(1,769,132)	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)	\$ 2,665,803	\$ 2,656,982	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,170,721	\$ 3,161,900	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 25,968	\$ 25,968	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	16,018	16,018	30
31	Accrued Taxes Payable	4,224	4,224	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See SCH 7A	12,940	12,940	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 59,149	\$ 59,149	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	2,143,750	2,143,750	38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	SECURITY DEPOSITS	19,161	19,161	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 2,162,911	\$ 2,162,911	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,222,060	\$ 2,222,060	45
46	TOTAL EQUITY	\$ 948,661	\$ 939,840	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 3,170,721	\$ 3,161,900	47

*(See instructions.)

Schedule 7A

XI. Balance Sheet

C. Current Liabilities

Line 35: Other Current Liabilities

	Description	Operating	After Consolidation
2235	Employee Deductions - Garnishments	\$ 185	\$ 185
2250	Employee Deductions - Misc.	\$ 263	\$ 263
2260	Section 125	\$ 395	\$ 395
2265	IMRF Insurance	\$ 8	\$ 8
2290	IMRF Retirement	\$ 984	\$ 984
2335	Resident Trust	\$ 11,105	\$ 11,105
		<u>\$ 12,940</u>	<u>\$ 12,940</u>

Facility Name: Maple Point

Report Period Beginning: 12/01/2018

Ending:

11/30/2019

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

		1	
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,231,936	1
2	Discounts and Allowances	(81,904)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,150,032	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	7,948	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,948	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	435	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 435	14
	D. Other Revenue (specify):		
15	Fundraising Activities	510	15
16	Sec SCH 8A	84,358	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 84,868	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,243,283	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	339,667	19
20	Health Care/ Personal Care	297,448	20
21	General Administration	203,535	21
	B. Capital Expense		
22	Ownership	207,814	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)	\$ 1,048,464	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 194,819	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 194,819	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 294,962	32
33	Private Pay - Net Inpatient Revenue	855,070	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,150,032	37

XII. Income Statement

D. Other Revenue

Line 16: Other Revenue

Description		Operating
4706	Miscellaneous Income	\$ 5,878.00
4721	IMRF Revenue	\$ 33,231.00
4722	Social Security Revenue	\$ 37,978.00
4723	Unemployment Revenue	\$ 7,271.00
		\$ 84,358.00