

		FOR BHF USE			

LL2

Supportive Living Facility

**2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)**

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 North 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:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 12/1/09 to 11/30/10 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) <u>See Accountant's Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>Margel S. Peddicord</u> <u>CPA</u>	
	(Firm Name & Address) <u>Margel S. Peddicord, CPA</u> <u>5300 Jaeger Dr., Springfield, IL 62711</u>	
	(Telephone) <u>217-787-8554</u> Fax # () _____	

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

Name: Margel S. Peddicord, CPA **Telephone Number:** 217-787-8554
Email Address: _____

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: 12/1/09 Ending: 11/30/10

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units / /

	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	30	Single Unit Apartment	30	10,950	1
2		Double Unit Apartment			2
3		Other			3
4	30	TOTALS	30	10,950	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	938	9,987		10,925	5
6	Double Unit					6
7	Other					7
8	TOTALS	938	9,987		10,925	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.77%

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

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)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: Fiscal Year:

* 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: Maple Point

Report Period Beginning:

12/1/09

Ending:

11/30/10

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	72,679	68,439	2,355	143,473	(2,143)	141,330	1
2	Housekeeping, Laundry and Maintenance	11,185	4,186	12,437	27,808		27,808	2
3	Heat and Other Utilities			42,751	42,751		42,751	3
4	Other (specify):							4
5	TOTAL General Services	83,864	72,625	57,543	214,032	(2,143)	211,889	5
B. Health Care and Programs								
6	Health Care/ Personal Care	182,809	953		183,762		183,762	6
7	Activities and Social Services	8,663	2,723	1,474	12,860		12,860	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	191,472	3,676	1,474	196,622		196,622	9
C. General Administration								
10	Administrative and Clerical	43,339	1,700	61,585	106,624		106,624	10
11	Marketing Materials, Promotions and Advertising			1,074	1,074		1,074	11
12	Employee Benefits and Payroll Taxes			72,166	72,166		72,166	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify): Bad Debt			1,746	1,746	(1,746)		14
15	TOTAL General Administration	43,339	1,700	136,571	181,610	(1,746)	179,864	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	318,675	78,001	195,588	592,264	(3,889)	588,375	16
Capital Expenses								
D. Ownership								
17	Depreciation				155,001		155,001	17
18	Interest				137,589		137,589	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				292,590		292,590	23
24	GRAND TOTAL (Sum of lines 16 and 23)	318,675	78,001	195,588	884,854	(3,889)	880,965	24

Facility Name: Maple Point

Report Period Beginning: 12/1/09

Ending:

11/30/10

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	0.62	18.40	2
3	Certified Nurse Assistants	6.87	11.14	3
4	Activity Director & Assistants	0.40	10.44	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.82	12.41	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0.57	9.51	10
11	Laundry			11
12	Managers	1.05	19.82	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	12.33	\$	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

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
_____		_____	
_____		_____	
_____		_____	

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: _____ 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. (B) Management fees paid to unrelated parties

Amount of Fee

1		\$	1
2			2
Total		\$	3

Facility Name: Maple Point

Report Period Beginning:

12/1/09

Ending:

11/30/10

VIII. OWNERSHIP COSTSA. Purchase price of land 88,390 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	\$	\$ 250,222	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Grounds Landscaping		2009	36,739	3,674	10	3,674		5,511	6
7		Alarm & Nurse Call System		2008	80,703	9,687	8	9,687		19,374	7
8		Window treatments and decorating		2009	28,899	5,446	6	5,446		8,168	8
9		Building improvement		2010	8,783	146	30	146		146	9
10		Landscaping		2010	875	44	10	44		44	10
11		Door Panel		2010	2,230	74	15	74		74	11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,926,922	\$ 144,694		\$ 144,694	\$	\$ 283,539	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	\$ 119,247	\$ 10,307	\$ 10,307	\$	various	\$ 18,500	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 119,247	\$ 10,307	\$ 10,307	\$		\$ 18,500	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: **12/1/09**

Ending: **11/30/10**

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	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	Name of Lender	2		3	4	6		7	8	9						
			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	/ /	\$	\$ 3,125,000	/ /		\$ 137,589	1					
2						/ /			/ /			2					
3						/ /			/ /			3					
		Working Capital															
4						/ /			/ /			4					
5						/ /			/ /			5					
6						/ /			/ /			6					
7		TOTAL Facility Related					\$	\$ 3,125,000			\$ 137,589	7					
		B. Non-Facility Related															
8						/ /			/ /			8					
9						/ /			/ /			9					
10		TOTALS (lines 7, 8 and 9)					\$	\$ 3,125,000			\$ 137,589	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: **12/1/09**

Ending:

11/30/10**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/10**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,079,508	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	24,913		3
4	Supply Inventory (priced at)	4,782		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)	\$ 1,109,203	\$	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	3,926,922		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	119,247		16
17	Accumulated Depreciation (book methods)	(302,039)		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)	\$ 3,832,520	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,941,723	\$	25

*(See instructions.)

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 14,739	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,864		30
31	Accrued Taxes Payable	9,177		31
32	Accrued Interest Payable	22,177		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Security Deposits	45,162		35
36	Due to PCNH	329,068		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 436,187	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,165,000		39
40	Bonds Payable	1,960,000		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)	\$ 3,125,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,561,187	\$	45
46	TOTAL EQUITY	\$ 1,380,536	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 4,941,723	\$	47

Facility Name: Maple Point

Report Period Beginning: 12/1/09

Ending:

11/30/10

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	\$ 1,093,526	1
2	Discounts and Allowances	(24,215)	2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,069,311	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	1,959	8
9	Non-Resident Meals	2,143	9
10	Laundry		10
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 4,102	11
C. Non-Operating Revenue			
12	Contributions	71,194	12
13	Interest and Other Investment Income	3,743	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 74,937	14
D. Other Revenue (specify):			
15			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,148,350	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	214,032	19
20	Health Care/ Personal Care	196,622	20
21	General Administration	181,610	21
B. Capital Expense			
22	Ownership	292,590	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)	\$ 884,854	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 263,496	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ 263,496	31