

		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.

<p><b>I. Facility ID Number:</b> <u>1000108</u></p> <p><b>Facility Name:</b> <u>Maple Point</u></p> <hr/> <p><b>Address:</b> <u>1000 Union Drive</u> <u>Monticello</u> <u>61856</u></p> <p align="center">Number City Zip Code</p> <p><b>County:</b> <u>Piatt</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>762-6665</u> Fax # <u>217 762-2507</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>12/10/08</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input checked="" type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Margel S. Peddicord, CPA</u> <b>Telephone Number:</b> ( <u>618-315-6242</u> )  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/11</u> to <u>11/30/12</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 align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            _____            (Type or Print Name)            _____            (Title)         </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) <u>See Accountant's Preparation Report</u>            _____            (Date)            (Print Name and Title) <u>Margel S. Peddicord</u>  <u>CPA</u>            (Firm Name &amp; Address) <u>Margel S. Peddicord, CPA</u>  <u>2616 Windcrest Dr., Mt. Vernon, IL 62864</u>            (Telephone) <u>618</u> ) <u>315-6242</u> Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>IL DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ _____ (Type or Print Name) _____ (Title)	<b>Paid Preparer</b>	(Signed) <u>See Accountant's Preparation 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>2616 Windcrest Dr., Mt. Vernon, IL 62864</u> (Telephone) <u>618</u> ) <u>315-6242</u> Fax # ( ) _____
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<b>Officer or Administrator of Provider</b>	(Signed) _____ _____ (Type or Print Name) _____ (Title)							
<b>Paid Preparer</b>	(Signed) <u>See Accountant's Preparation 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>2616 Windcrest Dr., Mt. Vernon, IL 62864</u> (Telephone) <u>618</u> ) <u>315-6242</u> Fax # ( ) _____							

Facility Name Maple Point

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

**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	14	Single Unit Apartment	14	5,124	1
2	16	Double Unit Apartment	16	5,856	2
3		Other			3
4	30	TOTALS	30	10,980	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	864	3,879		4,743	5
6	Double Unit		5,806		5,806	6
7	Other					7
8	TOTALS	864	9,685		10,549	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.07%

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)

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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:

12/1/11

Ending:

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			
<b>A. General Services</b>								
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	<b>TOTAL General Services</b>	<b>101,796</b>	<b>97,982</b>	<b>64,137</b>	<b>263,915</b>		<b>263,915</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
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	<b>TOTAL Health Care and Programs</b>	<b>239,434</b>	<b>1,039</b>	<b>16,233</b>	<b>256,705</b>		<b>256,705</b>	<b>9</b>
<b>C. General Administration</b>								
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	<b>TOTAL General Administration</b>	<b>47,229</b>	<b>6,837</b>	<b>163,495</b>	<b>217,560</b>		<b>217,560</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>388,458</b>	<b>105,857</b>	<b>243,865</b>	<b>738,181</b>		<b>738,181</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
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	<b>TOTAL Ownership</b>			<b>379,839</b>	<b>379,839</b>		<b>379,839</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>388,458</b>	<b>105,857</b>	<b>623,704</b>	<b>1,118,019</b>		<b>1,118,019</b>	<b>24</b>

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	<b>Total (lines 1 thru 16)</b>	<b>13.10</b>	<b>\$</b>	<b>17</b>

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	
				<b>Total</b>	<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee		
1	\$ NA	1	
2		2	
<b>Total</b>		<b>\$</b>	<b>3</b>

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	

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).

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
<b>Improvement Type</b>											
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

Facility Name: Maple Point

Report Period Beginning: 12/1/11

Ending: 11/30/12

**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	<b>TOTAL</b>				\$			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				
			YES	NO			Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1				X	Mortgage & Bonds	/ /	\$	3,035,000	/ /		\$	222,888
2						/ /			/ /			
3						/ /			/ /			
<b>Working Capital</b>												
4						/ /			/ /			
5						/ /			/ /			
6						/ /			/ /			
7		<b>TOTAL Facility Related</b>					\$	3,035,000			\$	222,888
<b>B. Non-Facility Related</b>												
8						/ /			/ /			
9						/ /			/ /			
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$	3,035,000			\$	222,888

\* 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: **12/1/11**

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*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,056,950</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 3,536,605</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 4,593,556</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
35	Security deposit liability	40,529		35
36	Intercompany PCNH	(170,091)		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	<b>\$ (59,184)</b>	<b>\$</b>	<b>37</b>
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,115,000		39
40	Bonds Payable	1,920,000		40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	<b>\$ 3,035,000</b>	<b>\$</b>	<b>44</b>
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	<b>\$ 2,975,816</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL EQUITY</b>	<b>\$ 1,617,740</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	<b>\$ 4,593,556</b>	<b>\$</b>	<b>47</b>

\*(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.)

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

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	263,915	19
20	Health Care/ Personal Care	256,705	20
21	General Administration	217,560	21
<b>B. Capital Expense</b>			
22	Ownership	379,839	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 1,118,019</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 45,364</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 45,364</b>	<b>31</b>



