

		FOR BHF USE			

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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>I. Facility ID Number: <u>1000108</u></p> <p>Facility Name: <u>Maple Point</u></p> <p>Address: <u>1000 Union Drive</u> <u>Monticello</u> <u>61856</u> <small>Number City Zip Code</small></p> <p>County: <u>Piatt</u></p> <p>Telephone Number: <u>(217) 762-2506</u> Fax # <u>(217) 762-2507</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>12/10/2008</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 282 - 6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" 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	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/2014</u> to <u>11/30/2015</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>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) _____ (Title) _____ </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Marcum LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																											
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Facility Name Maple Point

Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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	30	Single Unit Apartment	30	11,577	1
2		Double Unit Apartment			2
3		Other			3
4	30	TOTALS	30	11,577	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	2,160	8,786		10,946	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,160	8,786		10,946	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.55%

D. Indicate the number of paid bed-hold days the SLF had during this year 631 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 0 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2015 Fiscal Year: 11/30/2015

* 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? N/A

If no, explain. N/A

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? 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 principle? N/A

If no, explain. N/A

Facility Name: Maple Point

Report Period Beginning:

12/1/2014

Ending: 11/30/2015

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	83,702	99,221	2,746	185,669	(5,493)	180,176	1
2	Housekeeping, Laundry and Maintenance	34,208	9,804	19,386	63,398	2,537	65,935	2
3	Heat and Other Utilities			42,371	42,371		42,371	3
4	Other (specify):							4
5	TOTAL General Services	117,910	109,025	64,503	291,438	(2,956)	288,482	5
B. Health Care and Programs								
6	Health Care/ Personal Care	243,238	703		243,941		243,941	6
7	Activities and Social Services	20,059	4,002	20,545	44,606		44,606	7
8	Other (specify):		3	63	66	(66)		8
9	TOTAL Health Care and Programs	263,297	4,708	20,608	288,613	(66)	288,547	9
C. General Administration								
10	Administrative and Clerical	51,623	4,987	101,647	158,257	(15,741)	142,516	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			113,776	113,776		113,776	12
13	Insurance-Property, Liability and Malpractice							13
14	Other (specify):							14
15	TOTAL General Administration	51,623	4,987	215,423	272,033	(15,741)	256,292	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	432,830	118,720	300,534	852,084	(18,764)	833,320	16
Capital Expenses								
D. Ownership								
17	Depreciation			153,240	153,240	31,319	184,559	17
18	Interest			121,200	121,200	(897)	120,303	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			274,440	274,440	30,422	304,862	23
24	GRAND TOTAL (Sum of lines 16 and 23)	432,830	118,720	574,974	1,126,524	11,658	1,138,182	24

Maple Point

Report Period Beginning: 12/1/2014
Ending: 11/30/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	\$ 31,319	17	1
2	Telephone Income	(5,123)	10	2
3	Cable Income	(7,369)	10	3
4	Courtesy Cart	(3)	01	4
5	Staff Meals	(5,490)	01	5
6	Interest Income	(897)	18	6
7	Miscellaneous Income	(2,166)	10	7
8	Beauty Shop Supplies	(3)	08	8
9	Nail Care Expense	(63)	08	9
10	Public Ed Information	(323)	10	10
11	Development Expenses	(760)	10	11
12	Additional R&M	2,537	02	12
13				13
14				14
15				15
16				16
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99			99
100			100

101	Total	11,658	101
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Facility Name: Maple Point

Report Period Beginning 12/1/2014 Ending: 11/30/2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.08	\$ 23.68	1
2	Licensed Practical Nurses	0.83	26.96	2
3	Certified Nurse Assistants	6.88	13.46	3
4	Activity Director & Assistants	0.80	12.02	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	2.70	14.90	7
8	Dishwashers			8
9	Maintenance Workers	0.61	14.85	9
10	Housekeepers	0.63	11.84	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.96	25.81	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	13.49	\$ 15.42	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	\$	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

Name	1	City	2
Piatt County Nursing Home		Monticello	
Piatt County		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:

12/1/2014

Ending:

11/30/2015

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	\$	\$ 877,521	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Total From Supplemental Page 5's				204,580	27,889		16,399	16,399	127,292	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 3,973,273	\$ 153,240		\$ 141,750	\$ 16,399	\$ 1,004,813	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	\$ 161,751	\$	\$ 14,920	14,920		\$ 81,659	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	\$ 161,751	\$	\$ 14,920	14,920		\$ 81,659	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

STATE OF ILLINOIS

Facility Name & ID Number Maple Point

Report Period Beginning:

12/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	Ac
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
1							
2	Improvements	2008	80,703	20	9,687	9,687	
3	Improvements	2009	36,739	20	3,674	3,674	
4	Improvements	2009	28,899	20			
5	Improvements	2010	8,783	20	293	293	
6	Improvements	2010	875	20	88	88	
7	Improvements	2010	2,230	20	149	149	
8	Improvements	2012	2,897	20	290	290	
9	Improvements	2012	899	20	90	90	
10	Door	2014	2,819	20	141	141	
11	Call Lights	2015	39,736	20	1,987	1,987	
12							
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33							
34	TOTAL (lines 1 thru 33)		\$ 204,580	\$	\$ 16,399	\$ 16,399	\$

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

9	
Accumulated	
depreciation	
	1
67,809	2
23,881	3
28,899	4
1,611	5
484	6
819	7
1,160	8
360	9
282	10
1,987	11
	12
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127,292	34

STATE OF ILLINOIS

Facility Name & ID Number Maple Point

Report Period Beginning:

12/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	Ac
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
1							
2							
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34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$

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

9 Accumulated Depreciation	
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STATE OF ILLINOIS

Facility Name & ID Number Maple Point

Report Period Beginning:

12/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	Ac
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	De
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31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

9 Accumulated Depreciation	
	1
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Facility Name: Maple Point

Report Period Beginning: 12/1/2014

Ending: 1/30/2015

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	
		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	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		/ /	\$	905,000	/ /		\$ 41,158
2	Revenue Bonds		X		/ /		1,760,000	/ /		80,042
3					/ /			/ /		
	Working Capital									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$	2,665,000			\$ 121,200
	B. Non-Facility Related									
8	Interest Income		X		/ /			/ /		(897)
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$	2,665,000			\$ 120,303

* 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: **12/1/2014**

Ending:

11/30/2015**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/2015**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 944,430	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	919,543		3
4	Supply Inventory (priced at)	7,498		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)	\$ 1,871,471	\$	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	3,820,030		14
15	Leasehold Improvements, at Historical Cost	153,643		15
16	Equipment, at Historical Cost	168,508		16
17	Accumulated Depreciation (book methods)	(1,078,529)		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)	\$ 3,152,042	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,023,513	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (131,016)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,495		30
31	Accrued Taxes Payable	239,591		31
32	Accrued Interest Payable	9,261		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	29,046		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 158,377	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	905,000		39
40	Bonds Payable	1,760,000		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)	\$ 2,665,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,823,377	\$	45
46	TOTAL EQUITY	\$ 2,200,136	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,023,513	\$	47

*(See instructions.)

Facility Name: Maple Point

Report Period Beginning: 12/1/2014

Ending:

11/30/2015

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	\$ 1,173,228	1
2	Discounts and Allowances	(68,457)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,104,771	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	2,235	8
9	Non-Resident Meals	5,490	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 7,725	11
C. Non-Operating Revenue			
12	Contributions	35,000	12
13	Interest and Other Investment Income	897	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 35,897	14
D. Other Revenue (specify):			
15	See Attached	129,988	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 129,988	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,278,381	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	291,438	19
20	Health Care/ Personal Care	288,613	20
21	General Administration	272,033	21
B. Capital Expense			
22	Ownership	274,440	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)	\$ 1,126,524	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 151,857	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 151,857	31