

		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: 1000072

Facility Name: Magnolia Terrace

Address: 623 Hamacher Street Waterloo 62298

Number City Zip Code

County: Monroe

Telephone Number: (618) 939-3488 Fax # (618) 939-5030

Federal Employer ID Number:

Date Current Owners were Certified: 11/14/1950

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: Ken Marx Telephone Number: (314) 231-5544

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 12/1/2009 to 11/30/2010 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)		(Date)	
	(Print Name and Title)	Ken Marx Partner		
	(Firm Name & Address)	BKD, LLP 211 N Broadway, Suite 600, St. Louis MO 63102		
	(Telephone)	(314) 231-5544 Fax # (314) 231-9731		
	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 Magnolia Terrace

Report Period Beginning: 12/1/2009 Ending: 11/30/2010

III. STATISTICAL DATA

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

Date of change in certified units 12/1/2007

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	43	Single Unit Apartment	43	15,695
2	7	Double Unit Apartment	7	2,555
3		Other		
4	50	TOTALS	50	18,250

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	5,954	8,987		14,941	5
6 Double Unit	365	2,190		2,555	6
7 Other					7
8 TOTALS	6,319	11,177		17,496	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.87%

D. Indicate the number of paid bed-hold days the SLF had during this year 695 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: 11/30/10 Fiscal Year: 11/30/10

* 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. No loans outstanding

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. No loans outstanding

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. No loans outstanding

Facility Name: Magnolia Terrace

Report Period Beginning:

12/1/2009

Ending:

11/30/2010

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

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	69,086	96,210		165,296		165,296	1
2	Housekeeping, Laundry and Maintenance	47,394	17,414		64,808		64,808	2
3	Heat and Other Utilities			124,250	124,250		124,250	3
4	Other (specify):							4
5	TOTAL General Services	116,480	113,624	124,250	354,354		354,354	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	224,039	98	250	224,387		224,387	6
7	Activities and Social Services	34,700			34,700		34,700	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	258,739	98	250	259,087		259,087	9
	C. General Administration							
10	Administrative and Clerical	105,662		477,914	583,576		583,576	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			178,298	178,298		178,298	12
13	Insurance-Property, Liability and Malpractice			45,743	45,743		45,743	13
14	Other (specify): Travel, Training, Misc.			2,992	2,992		2,992	14
15	TOTAL General Administration	105,662		704,947	810,609		810,609	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	480,881	113,722	829,447	1,424,050		1,424,050	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			12,995	12,995		12,995	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			12,995	12,995		12,995	23
24	GRAND TOTAL (Sum of lines 16 and 23)	480,881	113,722	842,442	1,437,045		1,437,045	24

Facility Name: Magnolia Terrace

Report Period Beginning 12/1/2009 Ending: 11/30/2010

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.35	\$ 27.36	1
2	Licensed Practical Nurses	0.14	20.72	2
3	Certified Nurse Assistants	7.02	13.74	3
4	Activity Director & Assistants	1.00	12.70	4
5	Social Service Workers			5
6	Head Cook	1.50	10.66	6
7	Cook Helpers/Assistants	2.00	8.62	7
8	Dishwashers			8
9	Maintenance Workers	0.75	11.90	9
10	Housekeepers	1.74	9.25	10
11	Laundry			11
12	Managers	1.00	26.64	12
13	Other Administrative	0.28	43.71	13
14	Clerical	1.00	10.93	14
15	Marketing	0.28	22.04	15
16	Other			16
17	Total (lines 1 thru 16)	17.06	\$ 18.76	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
Oak Hill	Waterloo

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. (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

Facility Name: Magnolia Terrace

Report Period Beginning:

12/1/2009

Ending:

11/30/2010

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			2007	2007	\$ 7,707,025	\$ 106,469	7	\$ 106,469	\$	\$ 425,876	1
2											2
3											3
4											4
5											5
6	Improvement Type										
6	Light Fixtures			2007	1,644	235	7	235		940	6
7	Laundry Room			2007	1,145	164	7	164		656	7
8	Washer & Dryer			2007	1,280	183	7	183		732	8
9	Glass Tinting			2008	1,395	199	7	199		597	9
10	Bird Aviary			2009	5,304	354	15	354		708	10
11	BT Floor - Dining Room Floor			2009	7,395		7				11
12	Panic Button			2007	1,341	268	5	268		804	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,726,529	\$ 107,872		\$ 107,872	\$	\$ 430,313	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	\$ N/A	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	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

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 \$ N/A

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					/ /	\$		/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$				\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$				\$	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: Magnolia Terrace

Report Period Beginning: 12/1/2009

Ending: 11/30/2010

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2010

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 2,841,856	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,733,975	3
4	Supply Inventory (priced at)		34,113	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		30,932	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		797,459	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 5,438,335	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		6,849,756	14
15	Leasehold Improvements, at Historical Cost		(4,707,767)	15
16	Equipment, at Historical Cost		1,398,891	16
17	Accumulated Depreciation (book methods)		(1,332,316)	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)	\$	\$ 2,208,564	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 7,646,899	25

*(See instructions.)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 163,973	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		418,208	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Other Liabilities		17,326	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$	\$ 599,507	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Other Long Term Liabilities		946,598	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$ 946,598	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$	\$ 1,546,105	45
46	TOTAL EQUITY	\$	\$ 6,100,794	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$	\$ 7,646,899	47

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/2009

Ending:

11/30/2010

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	\$ 1,735,019	1
2	Discounts and Allowances	(195,965)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 1,539,054	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	227	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,200	8
9	Non-Resident Meals		9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$ 2,427	11
	C. Non-Operating Revenue		
12	Contributions	(5)	12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ (5)	14
	D. Other Revenue (specify):		
15	Food Stamp Revenue	23,159	15
16	NH Revenue	8,946,771	16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 8,969,930	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 10,511,406	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	354,354	19
20	Health Care/ Personal Care	259,087	20
21	General Administration	810,609	21
	B. Capital Expense		
22	Ownership	12,995	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	NH Expenses	8,578,591	26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 10,015,636	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 495,770	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 495,770	31