

		FOR BHF USE			

LL2

Supportive Living Facility

2013

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2013)

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: 11/14/50

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: KEVIN WELLEN 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 12/01/2012 to 11/30/2013 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) _____	
Paid Preparer	(Title) _____	
	(Signed) _____	(Date) _____
	(Print Name and Title) <u>KEVIN WELLEN</u> <u>DIRECTOR</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>211 N. BROADWAY, STE 600 ST. LOUIS, MO 63102</u>	
	(Telephone) <u>314) 231-5544</u> Fax <u>(314) 231-9731</u>	

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: 12/01/2012 Ending: 11/30/2013

III. STATISTICAL DATA

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

Date of change in certified units 12/01/2007

	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	1
2	7	Double Unit Apartment	7	5,110	2
3		Other			3
4	50	TOTALS	50	20,805	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	5,643	8,213		13,856	5
6	Double Unit	80	3,281		3,361	6
7	Other					7
8	TOTALS	5,723	11,494		17,217	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 82.75%

D. Indicate the number of paid bed-hold days the SLF had during this year 238 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 69 (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: 11/30/13 Fiscal Year: 11/30/13

* 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: MAGNOLIA TERRACE

Report Period Beginning:

12/01/2012

Ending:

11/30/2013

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	120,439	110,627		231,066		231,066	1
2	Housekeeping, Laundry and Maintenance	58,571	21,583		80,154		80,154	2
3	Heat and Other Utilities			130,242	130,242		130,242	3
4	Other (specify):							4
5	TOTAL General Services	179,010	132,210	130,242	441,462		441,462	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	228,614	999		229,613		229,613	6
7	Activities and Social Services	33,864	5,422	5,641	44,927		44,927	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	262,478	6,421	5,641	274,540		i	9
	C. General Administration							
10	Administrative and Clerical	138,198	1,802	485,110	625,110		625,110	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			232,783	232,783		232,783	12
13	Insurance-Property, Liability and Malpractice			48,613	48,613		48,613	13
14	Other (specify):			2,593	2,593		2,593	14
15	TOTAL General Administration	138,198	1,802	769,099	909,099		909,099	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	579,686	140,433	904,982	1,625,101		1,350,561	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			19,564	19,564		19,564	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			19,564	19,564		19,564	23
24	GRAND TOTAL (Sum of lines 16 and 23)	579,686	140,433	924,546	1,644,665		1,370,125	24

Facility Name: MAGNOLIA TERRACE

Report Period Beginning 12/01/2012 Ending: 11/30/2013

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.00	\$ 27.09	1
2	Licensed Practical Nurses	0.65	19.89	2
3	Certified Nurse Assistants	6.99	13.88	3
4	Activity Director & Assistants	1.09	14.88	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	6.96	8.32	7
8	Dishwashers			8
9	Maintenance Workers	1.01	12.26	9
10	Housekeepers	1.95	8.10	10
11	Laundry			11
12	Managers	0.28	46.33	12
13	Other Administrative	1.70	15.49	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	21.63	\$ 13.85	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

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? \$

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:

12/01/2012

Ending:

11/30/2013

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	10	\$ 106,469	\$	745,283	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	LIGHT FIXTURES			2007	1,644	235	7	234	(1)	1,644	6
7	LAUNDRY ROOM			2007	1,145	164	7	161	(3)	1,145	7
8	WASHER & DRYER			2007	1,280	183	7	182	(1)	1,280	8
9	PANIC BUTTON			2007	1,341	268	5	1	(267)	1,341	9
10	GLASS TINTING			2008	1,395	199	7	199		1,194	10
11	BIRD AVIARY			2009	5,304	354	15	354		1,770	11
12	BT FLOOR- DINING ROOM FLOOR			2009	7,395	1,056	7	1,056		5,280	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,726,529	\$ 108,928		\$ 108,656	\$ (272)	\$ 758,937	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	\$	\$	\$	\$		\$	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: MAGNOLIA TERRACE

Report Period Beginning: 12/01/2012 Ending: 1/30/2013

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: **12/01/2012**Ending: **11/30/2013****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/2013**

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 3,239,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		1,743,262	3
4	Supply Inventory (priced at)		55,714	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		11,134	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 5,049,642	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		356,105	14
15	Leasehold Improvements, at Historical Cost		(125,807)	15
16	Equipment, at Historical Cost		564,422	16
17	Accumulated Depreciation (book methods)		(444,582)	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): INVESTMENTS		860,194	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,210,332	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 6,259,974	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 453,769	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		315,480	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35			40,781	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$	\$ 810,030	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable		614,527	38
39	Mortgage Payable			39
40	Bonds Payable			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)	\$	\$ 614,527	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$	\$ 1,424,557	45
46	TOTAL EQUITY	\$	\$ 4,835,417	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$	\$ 6,259,974	47

*(See instructions.)

Facility Name: MAGNOLIA TERRACE

Report Period Beginning: 12/01/2012 Ending: 11/30/2013

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,741,581	1
2	Discounts and Allowances	(190,592)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,550,989	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	180	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	2,015	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,195	11
	C. Non-Operating Revenue		
12	Contributions	493	12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 493	14
	D. Other Revenue (specify):		
15	FOODSTAMP REVENUE	13,288	15
16	NH REVENUE	9,500,709	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 9,513,997	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 11,067,674	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	441,462	19
20	Health Care/ Personal Care	274,540	20
21	General Administration	909,099	21
	B. Capital Expense		
22	Ownership	19,564	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	NH EXPENSES	9,553,719	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 11,198,384	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (130,710)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (130,710)	31

