

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2008)**

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.</b></p> <p>Facility Name: <u>Magnolia Terrace</u></p> <p>Address: <u>623 Hamcher</u> <u>Waterloo</u> <u>62298</u>        Number City Zip Code</p> <p>County: <u>Monroe</u></p> <p>Telephone Number: ( <u>618</u> ) <u>939-3488</u> Fax # ( <u>618</u> ) <u>939-5030</u></p> <p>Federal Employer ID Number: <u>37600648001</u></p> <p>Date Current Owners were Certified: <u>11/14/1950</u></p> <p>Type of Ownership:</p> <table border="0"> <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>Ken Marx</u> Telephone Number: ( <u>314</u> ) <u>231-5544</u>        Email Address: <u>kmarx@bkd.com</u></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><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>12/1/07</u> to <u>11/30/08</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 border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____</td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Ken Marx</u> <u>Partner</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>BKD, LLP</u> <u>501 N Broadway ST 600, St. Louis MO 63102</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(314 ) 231-5544</u> Fax <u>314-231-9731</u></td> <td></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) _____	(Date) _____	(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Ken Marx</u> <u>Partner</u>		(Firm Name & Address) <u>BKD, LLP</u> <u>501 N Broadway ST 600, St. Louis MO 63102</u>		(Telephone) <u>(314 ) 231-5544</u> Fax <u>314-231-9731</u>	
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Facility Name Magnolia Terrace

Report Period Beginning: 12/1/07 Ending: 11/30/08

**III. STATISTICAL DATA**

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

Date of change in certified units 12/1/07

	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	15,738	1
2	7	Double Unit Apartment	7	2,562	2
3		Other			3
4	50	TOTALS	50	18,300	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	5,810	7,943		13,753	5
6	Double Unit		2,091		2,091	6
7	Other					7
8	TOTALS	5,810	10,034		15,844	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 86.58%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 339 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)

N/A

**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/08 Fiscal Year: 11/30/08

\* 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:

12/1/07

Ending:

11/30/08

## 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	71,791	81,837		153,628		153,628	1
2	Housekeeping, Laundry and Maintenance	45,256	9,954		55,210		55,210	2
3	Heat and Other Utilities			107,091	107,091		107,091	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>117,047</b>	<b>91,791</b>	<b>107,091</b>	<b>315,929</b>		<b>315,929</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	228,173	404		228,577		228,577	6
7	Activities and Social Services	30,566			30,566		30,566	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>258,739</b>	<b>404</b>		<b>259,143</b>		<b>259,143</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	54,605		530,748	585,353	(471,118)	114,235	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			124,521	124,521		124,521	12
13	Insurance-Property, Liability and Malpractice			54,779	54,779		54,779	13
14	Other (specify): Travel, Training, Misc			3,906	3,906		3,906	14
15	<b>TOTAL General Administration</b>	<b>54,605</b>		<b>713,954</b>	<b>768,559</b>	<b>(471,118)</b>	<b>297,441</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>430,391</b>	<b>92,195</b>	<b>821,045</b>	<b>1,343,631</b>	<b>(471,118)</b>	<b>872,513</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			732	732	167,595	168,327	17
18	Interest							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>732</b>	<b>732</b>	<b>167,595</b>	<b>168,327</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>430,391</b>	<b>92,195</b>	<b>821,777</b>	<b>1,344,363</b>	<b>(303,523)</b>	<b>1,040,840</b>	<b>24</b>

Facility Name: Magnolia Terrace

Report Period Beginning 12/1/07 Ending: 11/30/08

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.20	\$ 22.37	1
2	Licensed Practical Nurses	0.40	20.00	2
3	Certified Nurse Assistants	7.83	12.59	3
4	Activity Director & Assistants	1.00	11.81	4
5	Social Service Workers			5
6	Head Cook	2.00	10.96	6
7	Cook Helpers/Assistants	1.65	7.75	7
8	Dishwashers			8
9	Maintenance Workers	0.60	11.42	9
10	Housekeepers	2.00	7.75	10
11	Laundry			11
12	Managers	0.91	24.02	12
13	Other Administrative	0.23	19.96	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>16.82</b>	<b>\$ 14.86</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				\$	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	\$	1
2		2
<b>Total</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
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).

Facility Name: Magnolia Terrace

Report Period Beginning:

12/1/07

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**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	\$	\$ 212,938	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Light Fixtures		2007	2007	1,644	235	7	235		470	6
7	Laundry Room		2007	2007	1,145	164	7	164		328	7
8	Washer & Dryer		2007	2007	1,280	183	7	183		366	8
9	Panic Buttons		2008	2008	1,342	268	5	268		268	9
10	Window Tinting		2008	2008	1,395	199	7	199		199	10
11											11
12											12
13											13
14											14
15											15
16											16
17	<b>TOTAL (lines 1 thru 16)</b>				\$ 7,713,831	\$ 107,518		\$ 107,518	\$	\$ 214,569	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	<b>TOTAL (lines 18 and 19)</b>		\$	\$	\$		\$	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	<b>TOTALS (lines 21, 22 and 23)</b>		\$	\$	24

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/07

Ending: 11/30/08

**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	<b>TOTAL</b>				\$			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			
	<b>A. Directly Facility Related Long-Term</b>									
1					/ /	\$		/ /		\$
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4					/ /			/ /		
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$				\$
	<b>B. Non-Facility Related</b>									
8					/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$				\$

\* 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: **12/1/07**

Ending:

**11/30/08****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **11/30/08**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 1,589,299	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		2,427,471	3
4	Supply Inventory (priced at )		22,085	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		29,533	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 4,068,388	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		6,807,273	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,352,458	16
17	Accumulated Depreciation (book methods)		(5,885,945)	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>	\$	\$ 2,273,786	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 6,342,174	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 167,105	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		359,225	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Miscellaneous		867,531	35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$	\$ 1,393,861	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			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>	\$	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$	\$ 1,393,861	45
46	<b>TOTAL EQUITY</b>	\$	\$ 4,948,313	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$	\$ 6,342,174	47

\*(See instructions.)

Facility Name: Magnolia Terrace

Report Period Beginning: 12/1/07

Ending:

11/30/08

**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	\$ 1,651,411	1
2	Discounts and Allowances	(179,562)	2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 1,471,849	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services	1,325	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,804	8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 3,129	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	496	12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 496	14
<b>D. Other Revenue (specify):</b>			
15	Food Stamp	13,279	15
16	NH Revenue	10,266,626	16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 10,279,905	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 11,755,379	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	315,929	19
20	Health Care/ Personal Care	259,143	20
21	General Administration	768,559	21
<b>B. Capital Expense</b>			
22	Ownership	732	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	NH expenses	9,378,539	26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 10,722,902	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 1,032,477	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 1,032,477	31