

FOR BHF USE					

LL2

Supportive Living Facility

**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)**

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>1000072</u></p> <p>Facility Name: <u>Magnolia Terrace</u></p> <p>Address: <u>623 Hamcher</u> <u>Waterloo</u> <u>62298</u> <small>Number City Zip Code</small></p> <p>County: <u>Monroe</u></p> <p>Telephone Number: (<u>618</u>) <u>939-3488</u> Fax # <u>618 939-5030</u></p> <p>Federal Employer ID Number: _____</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: _____</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>12/01/2010</u> to <u>12/01/2011</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" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Ken Marx</u> <u>Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>BKD, LLP</u> <u>211 N Broadway, Suite 600 St. Louis, MO 63102</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>314</u>) <u>231-5544</u> Fax <u>(314) 231-9731</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) _____	(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>211 N Broadway, Suite 600 St. Louis, MO 63102</u>		(Telephone) <u>314</u>) <u>231-5544</u> Fax <u>(314) 231-9731</u>
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Facility Name Magnolia Terrace

Report Period Beginning: 12/01/2010 Ending: 12/01/2011

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	2,555	2
3		Other			3
4	50	TOTALS	50	18,250	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	6,550	7,591		14,141	5
6	Double Unit	263	2,110		2,373	6
7	Other					7
8	TOTALS	6,813	9,701		16,514	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.49%

D. Indicate the number of paid bed-hold days the SLF had during this year 704 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: 11/30/11 Fiscal Year: 11/30/11

* 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 outstanding loans

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 outstanding loans

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 outstanding loans

Facility Name: Magnolia Terrace

Report Period Beginning:

12/01/2010

Ending: 12/01/2011

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	71,383	96,808		168,191		168,191	1
2	Housekeeping, Laundry and Maintenance	57,374	20,749		78,123		78,123	2
3	Heat and Other Utilities			131,432	131,432		131,432	3
4	Other (specify):							4
5	TOTAL General Services	128,757	117,557	131,432	377,746		377,746	5
B. Health Care and Programs								
6	Health Care/ Personal Care	240,774	1,271		242,045		242,045	6
7	Activities and Social Services	37,112			37,112		37,112	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	277,886	1,271		279,157		279,157	9
C. General Administration								
10	Administrative and Clerical	135,197		476,082	611,279		611,279	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			200,658	200,658		200,658	12
13	Insurance-Property, Liability and Malpractice			40,154	40,154		40,154	13
14	Other (specify):			2,614	2,614		2,614	14
15	TOTAL General Administration	135,197		719,508	854,705		854,705	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	541,840	118,828	850,940	1,511,608		1,511,608	16
Capital Expenses								
D. Ownership								
17	Depreciation			14,942	14,942	93,986	108,928	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			14,942	14,942	93,986	108,928	23
24	GRAND TOTAL (Sum of lines 16 and 23)	541,840	118,828	865,882	1,526,550	93,986	1,620,536	24

Facility Name: Magnolia Terrace

Report Period Beginning 12/01/2010 Ending: 12/01/2011

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.17	\$ 25.90	1
2	Licensed Practical Nurses	0.43	19.28	2
3	Certified Nurse Assistants	8.41	12.29	3
4	Activity Director & Assistants	1.00	12.96	4
5	Social Service Workers			5
6	Head Cook	1.50	11.05	6
7	Cook Helpers/Assistants	2.00	8.88	7
8	Dishwashers			8
9	Maintenance Workers	1.09	11.31	9
10	Housekeepers	1.81	8.49	10
11	Laundry			11
12	Managers	1.00	26.78	12
13	Other Administrative	0.28	43.15	13
14	Clerical	1.66	11.92	14
15	Marketing	0.28	23.46	15
16	Other			16
17	Total (lines 1 thru 16)	19.63	\$	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
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:

12/01/2010

Ending:

12/01/2011

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	40	\$ 106,469	\$	\$ 532,345	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Light Fixtures		2007	1,644	235	7	235		1,175	6
7		Laundry Room		2007	1,145	164	7	164		820	7
8		Washer & Dryer		2007	1,280	183	7	183		915	8
9		Glass Tinting		2008	1,395	199	7	199		796	9
10		Bird Aviary		2009	5,304	354	15	354		1,062	10
11		BT Floor - Dining Room Floor		2009	7,395	1,056	7	1,056		3,168	11
12		Panic Button		2007	1,341	268	5	268		1,072	12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,726,529	\$ 108,928		\$ 108,928	\$	\$ 541,353	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

Facility Name: Magnolia Terrace

Report Period Beginning: 12/01/2010

Ending: 2/01/2011

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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			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: 12/01/2010

Ending:

12/01/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/01/2011

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,498,417	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		3,768,660	3
4	Supply Inventory (priced at)		36,578	4
5	Short-Term Investments			5
6	Prepaid Insurance		11,498	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		524,388	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 5,839,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		174,249	14
15	Leasehold Improvements, at Historical Cost		(60,876)	15
16	Equipment, at Historical Cost		443,587	16
17	Accumulated Depreciation (book methods)		(362,145)	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):		895,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 1,089,815	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 6,929,356	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 265,894	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		422,290	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35			64,181	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$	\$ 752,365	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			513,900	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$ 513,900	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$	\$ 1,266,265	45
46	TOTAL EQUITY	\$	\$ 5,663,091	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$	\$ 6,929,356	47

*(See instructions.)

Facility Name: Magnolia Terrace

Report Period Beginning: 12/01/2010

Ending:

12/01/2011

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	\$ 1,635,693	1
2	Discounts and Allowances	(151,788)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,483,905	3
B. Other Operating Revenue			
4	Special Services		4
5	Other Health Care Services	381	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,962	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 2,343	11
C. Non-Operating Revenue			
12	Contributions	723	12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 723	14
D. Other Revenue (specify):			
15	Food Stamp Revenue	31,495	15
16	NH Revenue	10,361,328	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 10,392,823	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 11,879,794	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	377,746	19
20	Health Care/ Personal Care	279,157	20
21	General Administration	854,705	21
B. Capital Expense			
22	Ownership	14,942	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	NH Expenses	10,789,834	26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 12,316,384	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (436,590)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (436,590)	31

