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 (Number) WATERLOO (City) 62298 (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	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) KEVIN WELLEN, DIRECTOR
(Firm Name & Address) BKD, LLP, 211 N. BROADWAY, STE 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: 12/01/2012 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 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [X] 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 [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] 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	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
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

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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	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 [X]
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 [X] 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: 12/01/2012 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 [X] NO

		1 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 [X] 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

	Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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	1 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	2 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