FOR BHF USE

LL2

Supportive Living Facility

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)

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: 11/14/1950

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2014 to 11/30/2015 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)

(Firm Name & Address) Marcum LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 282-6300 Fax (847) 282-6301

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282 - 6300
Email Address:

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: 12/1/2014 Ending: 11/30/2015

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,409	7,853		14,262	5
6	Double Unit	661	2,947		3,608	6
7	Other					7
8	TOTALS	7,070	10,800		17,870	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.92%

D. Indicate the number of paid bed-hold days the SLF had during this year 560 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 19 **(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)

N/A

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO

Tax Year: 11/30/2015 Fiscal Year: 11/30/2015

* 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: 12/1/2014 Ending: 11/30/2015**

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	128,242	109,616		237,858	(213)	237,645	1
2	Housekeeping, Laundry and Maintenance	60,302	25,118	43,032	128,452		128,452	2
3	Heat and Other Utilities			101,729	101,729		101,729	3
4	Other (specify):							4
5	**TOTAL General Services**	188,544	134,734	144,761	468,039	(213)	467,826	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	226,073	145		226,218		226,218	6
7	Activities and Social Services	58,485	4,993	6,060	69,538	(1,036)	68,502	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	284,558	5,138	6,060	295,756	(1,036)	294,720	9
	C. General Administration							
10	Administrative and Clerical	107,892	3,964	52,291	164,147	(12,820)	151,327	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			185,587	185,587		185,587	12
13	Insurance-Property, Liability and Malpractice			47,916	47,916		47,916	13
14	Other (specify):							14
15	**TOTAL General Administration**	107,892	3,964	285,794	397,650	(12,820)	384,830	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	580,994	143,836	436,615	1,161,445	(14,068)	1,147,377	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			14,560	14,560	101,656	116,216	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			12,473	12,473		12,473	21
22	Other (specify):	4,342,932	587,283	4,800,368	9,730,583	(9,730,583)		22
23	**TOTAL Ownership**	4,342,932	587,283	4,827,401	9,757,616	(9,628,927)	128,689	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	4,923,926	731,119	5,264,016	10,919,061	(9,642,995)	1,276,066	24

Magnolia Terrace

Report Period Beginning: 12/1/2014
Ending: 11/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	$ 101,656	17	1
2	SNF Expenses	(9,367,549)	22	2
3	Public Relations	(6,980)	10	3
4	Advertising Facility Promotions	(3,888)	10	4
5	Advertising - Yellow Pages	(2,359)	10	5
6	Other Income	(15,826)	10	6
7	Vending in and out	(213)	01	7
8	Spirit Committee Activity	(1,036)	07	8
9	County Transfer	(363,034)	22	9
10				10
11				11
12	Monroe County:			12
13	County Administration	15,652	10	13
14	Administrative Assistant	581	10	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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99				99
100				100

101	**Total**	(9,642,995)		**101**

Facility Name: Magnolia Terrace **Report Period Beginning 12/1/2014 Ending: 11/30/2015**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		$	1
2	Licensed Practical Nurses	0.78	22.57	2
3	Certified Nurse Assistants	7.04	12.93	3
4	Activity Director & Assistants	1.46	14.52	4
5	Social Service Workers	0.27	25.67	5
6	Head Cook			6
7	Cook Helpers/Assistants	5.90	10.45	7
8	Dishwashers			8
9	Maintenance Workers	1.36	11.20	9
10	Housekeepers	1.43	9.60	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.24	29.19	13
14	Clerical	1.08	14.40	14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	21	$ 13.58	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	N/A			$	1
2					2
3					3
4					4
5					5
			Total	$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	$	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 (SNF)	Waterloo

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Monroe County	Waterloo, IL	County

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: N/A **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: 12/1/2014 Ending: 11/30/2015

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	$ 7,707,025	$ 14,560	35	$ 106,469	$ 91,909	$ 958,221	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				124,803			6,240	6,240	15,602	6
7	Various			2007	5,410		20	334	334	3,093	7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 7,837,238	$ 14,560		$ 113,044	$ 98,484	$ 976,916	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	$ 31,723	$	$ 3,172	3,172		$ 6,345	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	$ 31,723	$	$ 3,172	3,172		$ 6,345	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

STATE OF ILLINOIS

Facility Name & ID Number Magnolia Terrace Report Period Beginning: 12/1/2014 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
1								
2	Window Tinting	2008	1,395		20	70	70	
3	Bird Aviary	2009	5,304		20	265	265	
4	Bt Floor- Dining Room Floor	2009	7,395		20	370	370	
5	Gazebo- Allocated To Slf	2011	10,851		20	543	543	
6	1St Floor Bathroom Flooring	2014	8,193		20	410	410	
7	Signage	2014	6,550		20	328	328	
8	Kitchen Plumbing	2014	43,136		20	2,157	2,157	
9	New Flooring For 2Nd Floor	2015	23,902		20	1,195	1,195	
10	A/C Units	2015	13,410		20	671	671	
11	Warming Kitchen	2015	4,667		20	233	233	
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33								
34	TOTAL (lines 1 thru 33)		$ 124,803	$		$ 6,240	$ 6,240	$

**Improvement type must be detailed in order for the cost report to be considered complete.

9 ccumulated epreciation	
	1
558	2
1,856	3
2,588	4
2,713	5
819	6
655	7
4,314	8
1,195	9
671	10
233	11
	12
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STATE OF ILLINOIS

Facility Name & ID Number Magnolia Terrace **Report Period Beginning:** 12/1/2014 **Ending:**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
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34	TOTAL (lines 1 thru 33)		$	$		$	$	$

****Improvement type must be detailed in order for the cost report to be considered complete.**

9 ccumulated epreciation	
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STATE OF ILLINOIS

Facility Name & ID Number Magnolia Terrace **Report Period Beginning:** 12/1/2014 **Ending:**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
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34	TOTAL (lines 1 thru 33)		$	$		$	$	$

****Improvement type must be detailed in order for the cost report to be considered complete.**

9 ccumulated epreciation	
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Facility Name: Magnolia Terrace **Report Period Beginning:** 12/1/2014 **Ending:** 1/30/2015

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 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 ☐ NO

9. **Rental amount for movable equipment $** 12,473

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 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	N/A				/ /	$	$	/ /		$	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:** 12/1/2014 **Ending:** 11/30/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2015 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,245,846	$	1
2	Cash-Patient Deposits	10,018		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,253,494		3
4	Supply Inventory (priced at)	76,301		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	20,672		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,606,331	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	61,482		14
15	Leasehold Improvements, at Historical Cost	380,285		15
16	Equipment, at Historical Cost	676,471		16
17	Accumulated Depreciation (book methods)	(732,325)		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):	35,613		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 421,526	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,027,857	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 348,045	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,018		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	292,676		30
31	Accrued Taxes Payable	44,829		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36	See Attached	546,489		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,242,057	$	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				42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,242,057	$	45
46	**TOTAL EQUITY**	$ 4,785,800	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 6,027,857	$	47

***(See instructions.)**

Facility Name: Magnolia Terrace **Report Period Beginning: 12/1/2014 Ending: 11/30/2015**

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	$ 1,581,864	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,581,864	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	903	5
6	Special Grants		6
7	Gift and Coffee Shop	16,602	7
8	Barber and Beauty Care	10,286	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 27,791	11
	C. Non-Operating Revenue		
12	Contributions	60,456	12
13	Interest and Other Investment Income	7,132	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 67,588	14
	D. Other Revenue (specify):		
15		9,822,596	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 9,822,596	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 11,499,839	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	468,039	19
20	Health Care/ Personal Care	295,756	20
21	General Administration	397,650	21
	B. Capital Expense		
22	Ownership	9,757,616	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	**TOTAL EXPENSES (sum of lines 19 thru 27)**	$ 10,919,061	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 580,778	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 580,778	31