FOR BHF USE

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

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		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282 - 6300
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 12/1/2015 to 11/30/2016 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) *
** Subject to the attached Accountants Consulting Report*
(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

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: 12/1/2015 Ending: 11/30/2016

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	15,738	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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	6,882	7,228		14,110	5
6	Double Unit	710	2,712		3,422	6
7	Other					7
8	TOTALS	7,592	9,940		17,532	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.80%

D. Indicate the number of paid bed-hold days the SLF had during this year 502 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 0 **(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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [X] YES [ ] NO
Tax Year: 11/30/2016 Fiscal Year: 11/30/2016
* 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: 12/1/2015 Ending: 11/30/2016**

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	128,483	111,463		239,946	(212)	239,734	1
2	Housekeeping, Laundry and Maintenance	68,042	19,374	43,600	131,016		131,016	2
3	Heat and Other Utilities			97,083	97,083		97,083	3
4	Other (specify):							4
5	**TOTAL General Services**	196,525	130,837	140,683	468,045	(212)	467,833	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	241,254	1,769	31	243,054		243,054	6
7	Activities and Social Services	61,103	6,116	6,985	74,204	(2,232)	71,972	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	302,357	7,885	7,016	317,258	(2,232)	315,026	9
	C. General Administration							
10	Administrative and Clerical	122,279	3,917	63,326	189,522	(15,304)	174,218	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			175,858	175,858		175,858	12
13	Insurance-Property, Liability and Malpractice			41,064	41,064		41,064	13
14	Other (specify):							14
15	**TOTAL General Administration**	122,279	3,917	280,248	406,444	(15,304)	391,140	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	621,161	142,639	427,947	1,191,747	(17,748)	1,173,999	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			11,654	11,654	104,562	116,216	17
18	Interest							18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			14,748	14,748		14,748	21
22	Other (specify):	4,425,723	616,869	4,320,843	9,363,435	(9,363,435)		22
23	**TOTAL Ownership**	4,425,723	616,869	4,347,245	9,389,837	(9,258,873)	130,964	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	5,046,884	759,508	4,775,192	10,581,584	(9,276,621)	1,304,963	24

STATE OF ILLINOIS **Page 3A**

Magnolia Terrace

Report Period Beginning: **12/1/2015**
Ending: **11/30/2016**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	$ 104,562	17	1
2	Vending in and out	(212)	01	2
3	Other Income	(1,012)	10	3
4	Bad Debt	(1,912)	10	4
5	Public Relations	(8,050)	10	5
6	Advertising Facility Promotions	(13,829)	10	6
7	Advertising - Yellow Pages	(1,721)	10	7
8	Jail Meals Income	(3,548)	10	8
9	Resident Council Acct	(544)	10	9
10	Spirit Committee Activity	(2,232)	07	10
11	County Transfer	(280,266)	22	11
12	SNF Expenses	(9,083,169)	22	12
13				13
14				14
15	Monroe County:			15
16	County Administration	15,312	10	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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97				97
98				98
99				99
100				100
101	**Total**	(9,276,621)		101

Facility Name: Magnolia Terrace **Report Period Beginning: 12/1/2015 Ending: 11/30/2016**

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	1.02	22.38	2
3	Certified Nurse Assistants	7.39	12.60	3
4	Activity Director & Assistants	1.58	14.13	4
5	Social Service Workers	0.28	25.02	5
6	Head Cook			6
7	Cook Helpers/Assistants	6.17	10.02	7
8	Dishwashers			8
9	Maintenance Workers	1.29	14.24	9
10	Housekeepers	1.55	9.22	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1.27	33.36	13
14	Clerical	1.09	15.05	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	21.64	$ 13.80	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		OTHER RELATED BUSINESS ENTITIES		
Name 1	City 2	Name 3	City 4	Type of Business 5
Oak Hill (SNF)	Waterloo	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: 12/1/2015 Ending: 11/30/2016

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	50			2007	$ 7,707,025	$ 11,654	35	$ 106,469	$ 94,815	$ 1,064,690	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Total From Supplemental Page 5's				123,408			6,170	6,170	21,215	6
7	Various			2007	5,410		20	334	334	3,427	7
8	Various			2008	1,395		20	70	70	628	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	$ 11,654		$ 113,044	$ 101,390	$ 1,089,959	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		$ 9,517	18
19	Vehicles						-	19
20	TOTAL (lines 18 and 19)	$ 31,723	$	$ 3,172	3,172		$ 9,517	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 & ID Number Magnolia Terrace Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	9 Accumulated Depreciation	
1									1
2	Bird Aviary	2009	5,304		20	265	265	2,122	2
3	Bt Floor- Dining Room Floor	2009	7,395		20	370	370	2,958	3
4	Gazebo- Allocated To Slf	2011	10,851		20	543	543	3,255	4
5	1St Floor Bathroom Flooring	2014	8,193		20	410	410	1,229	5
6	Signage	2014	6,550		20	328	328	983	6
7	Kitchen Plumbing	2014	43,136		20	2,157	2,157	6,470	7
8	New Flooring For 2Nd Floor	2015	23,902		20	1,195	1,195	2,390	8
9	A/C Units	2015	13,410		20	671	671	1,341	9
10	Warming Kitchen	2015	4,667		20	233	233	467	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 123,408	$		$ 6,170	$ 6,170	$ 21,215	34

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

Facility Name & ID Number Magnolia Terrace Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	9 Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Magnolia Terrace Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	9 Accumulated Depreciation	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name: Magnolia Terrace **Report Period Beginning:** 12/1/2015 **Ending:** 1/30/2016

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 $** 14,748

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:** 12/1/2015 **Ending:** 11/30/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2016 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,072,902	$	1
2	Cash-Patient Deposits	10,125		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,671,892		3
4	Supply Inventory (priced at)	71,816		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,103		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,852,838	$	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	388,825		15
16	Equipment, at Historical Cost	691,933		16
17	Accumulated Depreciation (book methods)	(819,656)		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):	627,444		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 950,028	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,802,866	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 813,133	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,161		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	313,031		30
31	Accrued Taxes Payable	45,938		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	563,846		36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,746,109	$	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)**	$ 1,746,109	$	45
46	**TOTAL EQUITY**	$ 6,056,757	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 7,802,866	$	47

***(See instructions.)**

Facility Name: Magnolia Terrace **Report Period Beginning: 12/1/2015 Ending: 11/30/2016**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,650,734	1
2	Discounts and Allowances	(56)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,650,678	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	1,573	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	10,493	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 12,066	11
	C. Non-Operating Revenue		
12	Contributions	37,827	12
13	Interest and Other Investment Income	9,345	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 47,172	14
	D. Other Revenue (specify):		
15	**See Page 8-supp**	10,142,617	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 10,142,617	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 11,852,533	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	468,045	19
20	Health Care/ Personal Care	317,258	20
21	General Administration	406,444	21
	B. Capital Expense		
22	Ownership	9,389,837	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)**	$ 10,581,584	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 1,270,949	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 1,270,949	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 657,604	32
33	Private Pay - Net Inpatient Revenue	993,074	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,650,678	37