FOR BHF USE

LL2

Supportive Living Facility

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)

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: 1000130

Facility Name: Knollwood St Clair Ret Comm

Address: 921 Knollwood Drive (Number) Caseyville (City) 62232 (Zip Code)

County: St Clair

Telephone Number: (618) 394-0569 **Fax #** 618 394-0582

Federal Employer ID Number:

Date Current Owners were Certified: 4/30/11

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[X] Partnership	[ ] 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: Charles W. Fawcett, Jr. **Telephone Number:** (636 537-5900
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 01/01/2014 to 12/31/2014 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) Charles W. Fawcett, Jr.
(Title) President of General Partner

Paid Preparer

(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

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

Date of change in certified units: 12/31/14

	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	96	Single Unit Apartment	96	35,040	1
2	2	Double Unit Apartment	2	730	2
3		Other			3
4	98	TOTALS	98	35,770	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	25,831	4,183		30,014	5
6	Double Unit					6
7	Other					7
8	TOTALS	25,831	4,183		30,014	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 83.91%

D. Indicate the number of paid bed-hold days the SLF had during this year 698 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 13 **(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 [ ] NO [X]

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? [ ] YES [ ] NO
Tax Year: 12/2013 Fiscal Year: 12/2013
* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes **If yes, did the facility make all of the required payments of interest and principle?** Yes
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: Knollwood St Clair Ret Comm **Report Period Beginning: 01/01/2014 Ending: 12/31/2014**

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	261,288	24,977	204,887	491,152		491,152	1
2	Housekeeping, Laundry and Maintenance	151,820	15,525	77,875	245,220		245,220	2
3	Heat and Other Utilities			95,597	95,597		95,597	3
4	Other (specify):							4
5	**TOTAL General Services**	413,108	40,502	378,359	831,969		831,969	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	371,574	6,003	16,502	394,079		394,079	6
7	Activities and Social Services	35,818	8,039	7,040	50,897		50,897	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	407,392	14,042	23,542	444,976		444,976	9
	C. General Administration							
10	Administrative and Clerical	199,784	9,146	254,247	463,177		463,177	10
11	Marketing Materials, Promotions and Advertising			21,538	21,538		21,538	11
12	Employee Benefits and Payroll Taxes			143,818	143,818		143,818	12
13	Insurance-Property, Liability and Malpractice			85,588	85,588		85,588	13
14	Other (specify): Mortgage Insurance			45,462	45,462		45,462	14
15	**TOTAL General Administration**	199,784	9,146	550,653	759,583		759,583	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,020,284	63,690	952,554	2,036,528		2,036,528	16
	Capital Expenses							
	D. Ownership							
17	Depreciation & Amortization			455,950	455,950		455,950	17
18	Interest			585,996	585,996		585,996	18
19	Real Estate Taxes			47,495	47,495		47,495	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			1,089,441	1,089,441		1,089,441	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,020,284	63,690	2,041,995	3,125,969		3,125,969	24

Facility Name: Knollwood St Clair Ret Comm Report Period Beginning 01/01/2014 Ending: 12/31/2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	$ 21.75	1
2	Licensed Practical Nurses	3	17.50	2
3	Certified Nurse Assistants	8	9.60	3
4	Activity Director & Assistants	2	11.25	4
5	Social Service Workers			5
6	Head Cook	3	10.00	6
7	Cook Helpers/Assistants	6	8.25	7
8	Dishwashers	3	8.25	8
9	Maintenance Workers	2	11.38	9
10	Housekeepers	4	8.57	10
11	Laundry **Hsk Manager**	1	14.42	11
12	Managers **ADM**	1	26.45	12
13	Other Administrative			13
14	Clerical	4	10.34	14
15	Marketing	1	16.83	15
16	Other **Dietary Manager**	1	16.35	16
17	**Total (lines 1 thru 16)**	40	$ 11.44	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
N/A	

OTHER RELATED BUSINESS ENTITIES

Name 3	City 4	Type of Business 5
Knollwood Management Services	St. Louis	Management Co.

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: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 300,000 Year land was acquired 2011

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			2011	2011	$ 10,637,613	$ 302,515	40	$ 302,515	$	$ 1,048,967	1
2			2012	2012	63,681	1,877	40	1,877		5,565	2
3											3
4											4
5											5
	Improvement Type										
6											6
7											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)				$ 10,701,294	$ 304,392		$ 304,392	$	$ 1,054,532	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	Furnishing & Fixtures	$ 675,231	$ $ 129,804	$ $ 547,756	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 675,231	$ 129,804	$ 547,756	24

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning:** 01/01/2014 **Ending:** 2/31/2014

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 $

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	GERSHMAN		X	BUILDING	12/1/09	$ 10,338,000	$ 10,063,534	12/1/49	0.0580	$ 585,996	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	BUILDING	12/1/09	1,656,251	1,656,251	12/31/51	N/A	NONE	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 11,994,251	$ 11,719,785			$ 585,996	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 11,994,251	$ 11,719,785			$ 585,996	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: Knollwood St Clair Ret Comm **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 85,613	$ 85,613	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	406,748	406,748	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,118	43,118	6
7	Other Prepaid Expenses	27,403	27,403	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 562,882	$ 562,882	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,000	300,000	13
14	Buildings, at Historical Cost	10,701,294	10,701,294	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	675,231	675,231	16
17	Accumulated Depreciation (book methods)	(1,602,288)	(1,602,288)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	364,437	364,437	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intangibles	791,115	791,115	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,229,789	$ 11,229,789	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,792,671	$ 11,792,671	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,396,593	$ 1,396,593	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			31
32	Accrued Interest Payable	48,640	48,640	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 1,445,233	$ 1,445,233	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	10,063,534	10,063,534	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)**	$ 11,719,785	$ 11,719,785	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 13,165,018	$ 13,165,018	45
46	**TOTAL EQUITY**	$ (1,372,347)	$ (1,372,347)	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,792,671	$ 11,792,671	47

***(See instructions.)**

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning: 01/01/2014 Ending: 12/31/2014**

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	$ 2,689,720	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,689,720	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	1,044	8
9	Non-Resident Meals	9,084	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 10,128	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	855	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 855	14
	D. Other Revenue (specify):		
15			15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,700,703	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	831,969	19
20	Health Care/ Personal Care	444,976	20
21	General Administration	759,583	21
	B. Capital Expense		
22	Ownership	1,089,441	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)**	$ 3,125,969	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (425,266)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (425,266)	31