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: 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 01/01/2015 to 12/31/2015 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) 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: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

Date of change in certified units: / /

	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	28,378	1,460		29,838	5
6	Double Unit	1,014	365		1,379	6
7	Other					7
8	TOTALS	29,392	1,825		31,217	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.27%

D. Indicate the number of paid bed-hold days the SLF had during this year 469 **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 [ ] 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? [X] YES [ ] NO
Tax Year: 12/2015 Fiscal Year: 12/2015
* 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: 01/01/2015 Ending: 12/31/2015**

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	234,183	18,180	184,402	436,765		436,765	1
2	Housekeeping, Laundry and Maintenance	145,432	15,542	63,978	224,952		224,952	2
3	Heat and Other Utilities			82,196	82,196		82,196	3
4	Other (specify):							4
5	**TOTAL General Services**	379,615	33,722	330,576	743,913		743,913	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	365,140	6,682	7,736	379,558		379,558	6
7	Activities and Social Services	28,364	6,762	8,862	43,988		43,988	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	393,504	13,444	16,598	423,546		423,546	9
	C. General Administration							
10	Administrative and Clerical	230,938	13,204	266,533	510,675		510,675	10
11	Marketing Materials, Promotions and Advertising			29,632	29,632		29,632	11
12	Employee Benefits and Payroll Taxes			166,061	166,061		166,061	12
13	Insurance-Property, Liability and Malpractice			92,495	92,495		92,495	13
14	Other (specify): Mortgage Insurance			45,063	45,063		45,063	14
15	**TOTAL General Administration**	230,938	13,204	599,784	843,927		843,927	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,004,057	60,370	946,958	2,011,386		2,011,386	16
	Capital Expenses							
	D. Ownership							
17	Depreciation & Amortization			405,170	405,170		405,170	17
18	Interest			580,847	580,847		580,847	18
19	Real Estate Taxes			49,352	49,352		49,352	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			1,035,369	1,035,369		1,035,369	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,004,057	60,370	1,982,327	3,046,755		3,046,755	24

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning 01/01/2015 Ending: 12/31/2015**

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

	Personnel		Number of FTE	Average Hourly Wage	
1	Registered Nurses		1	$ 19.50	1
2	Licensed Practical Nurses		3	17.50	2
3	Certified Nurse Assistants		8	9.50	3
4	Activity Director & Assistants		1	13.46	4
5	Social Service Workers	DON	1	24.04	5
6	Head Cook		3	10.00	6
7	Cook Helpers/Assistants		6	8.36	7
8	Dishwashers		1	8.25	8
9	Maintenance Workers		2	11.38	9
10	Housekeepers		4	8.56	10
11	Laundry	Hsk. Mgr	1	14.42	11
12	Managers	Admin.	1	26.44	12
13	Other Administrative		1	15.38	13
14	Clerical		4	10.33	14
15	Marketing		1	16.83	15
16	Other	Diet. Mgr	1	16.35	16
17	**Total (lines 1 thru 16)**		39	$ 11.34	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: 01/01/2015 Ending: 12/31/2015

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	$ 312,491		$ 312,491	$	$ 1,361,458	1
2			2012	2012	63,681	1,877	40	1,877		7,442	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	$ 314,368		$ 314,368	$	$ 1,368,900	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	Furnishings & Fixtures	$ 677,414	$ $ 77,789	$ $ 568,627	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 677,414	$ 77,789	$ 568,627	24

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning:** 01/01/2015 **Ending:** 2/31/2015

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 $

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	$ 9,972,389	12/1/49	0.0580	$ 580,847	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	Building	12/1/09	1,656,251	1,656,251	12/31/51	None	None	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 11,994,251	$ 11,628,640			$ 580,847	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 11,994,251	$ 11,628,640			$ 580,847	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:** 01/01/2015 **Ending:** 12/31/2015

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,152	$ 95,152	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	378,974	378,974	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,921	44,921	6
7	Other Prepaid Expenses	27,160	27,160	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 546,207	$ 546,207	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	677,414	677,414	16
17	Accumulated Depreciation (book methods)	(1,937,526)	(1,937,526)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	421,948	421,948	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	771,873	771,873	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,935,003	$ 10,935,003	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,481,210	$ 11,481,210	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,301,198	$ 1,301,198	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	48,200	48,200	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)**	$ 1,349,398	$ 1,349,398	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	9,972,389	9,972,389	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)**	$ 11,628,640	$ 11,628,640	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 12,978,037	$ 12,978,037	45
46	**TOTAL EQUITY**	$ (1,496,827)	$ (1,496,827)	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 11,481,210	$ 11,481,210	47

***(See instructions.)**

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning: 01/01/2015 Ending: 12/31/2015**

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	$ 2,858,122	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,858,122	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	957	8
9	Non-Resident Meals	11,435	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 12,392	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	1,070	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 1,070	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)**	$ 2,871,584	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	743,913	19
20	Health Care/ Personal Care	423,546	20
21	General Administration	843,927	21
	B. Capital Expense		
22	Ownership	1,035,369	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)**	$ 3,046,755	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (175,171)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (175,171)	31