FOR BHF USE

LL2

Supportive Living Facility

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2011)

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 Name: St. Clair Supportive Living, LP

Address: 921 Knollwood Village Road (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: 04/30/11

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 12/01/2011 to 12/31/2011 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 St. Clair Supportive Living, LP Report Period Beginning: 12/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

Date of change in certified units 12/31/11

	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	98	Single Unit Apartment	98	24,010	1
2		Double Unit Apartment			2
3		Other			3
4	98	TOTALS	98	24,010	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	3,450 #			4,817	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,450			4,817	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 20.06%

D. Indicate the number of paid bed-hold days the SLF had during this year 168 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 20 **(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: 12/11 Fiscal Year: 12/11
* 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: St. Clair Supportive Living, LP **Report Period Beginning: 12/01/2011 Ending: 12/31/2011**

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	**76,108**	**16,664**	**45,508**	**138,280**		**138,280**	1
2	Housekeeping, Laundry and Maintenance	**65,893**	**15,978**	**(20,630)**	**61,241**		**61,241**	2
3	Heat and Other Utilities			**33,767**	**33,767**		**33,767**	3
4	Other (specify):							4
5	**TOTAL General Services**	**142,001**	**32,642**	**58,645**	**233,288**		**233,288**	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	**173,662**	**5,277**	**2,343**	**181,282**		**181,282**	6
7	Activities and Social Services	**6,012**		**4,636**	**10,648**		**10,648**	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	**179,674**	**5,277**	**6,979**	**191,930**		**191,930**	9
	C. General Administration							
10	Administrative and Clerical	**76,404**	**22,429**	**185,812**	**284,645**		**284,645**	10
11	Marketing Materials, Promotions and Advertising			**168,812**	**168,812**		**168,812**	11
12	Employee Benefits and Payroll Taxes			**86,603**	**86,603**		**86,603**	12
13	Insurance-Property, Liability and Malpractice			**70,517**	**70,517**		**70,517**	13
14	Other (specify): Mortgage Premium							14
15	**TOTAL General Administration**	**76,404**	**22,429**	**511,744**	**610,577**		**610,577**	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	**398,079**	**60,348**	**577,368**	**1,035,795**		**1,035,795**	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			**232,165**	**232,165**		**232,165**	17
18	Interest			**189,112**	**189,112**		**189,112**	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			**421,277**	**421,277**		**421,277**	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	**398,079**	**60,348**	**998,645**	**1,457,072**		**1,457,072**	24

Facility Name: St. Clair Supportive Living, LP **Report Period Beginning 12/01/2011 Ending: 12/31/2011**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 23.80	1
2	Licensed Practical Nurses	1	17.00	2
3	Certified Nurse Assistants	10	9.50	3
4	Activity Director & Assistants	1	8.50	4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	4	8.25	7
8	Dishwashers-incl with cooh assist above			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	2	8.25	10
11	Laundry **Hsk Manager**	1	14.42	11
12	Managers **Admin**	1	36.06	12
13	Other Administrative	1	16.83	13
14	Clerical	2	10.00	14
15	Marketing			15
16	Other **Dietary Mngr**	1	20.00	16
17	**Total (lines 1 thru 16)**	27	$ 12.00	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
Kno;wood Management Services	St. Louis	Management Compa

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: St. Clair Supportive Living, LP Report Period Beginning: 12/01/2011 Ending: 12/31/2011

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	$ 9,163,247	$ 114,540	40	$ 114,540	$	$ 114,540	1
2											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)				$ 9,163,247	$ 114,540		$ 114,540	$	$ 114,540	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					5		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	$ 2,148,373	$ $ 104,256	$ $ 104,256	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 2,148,373	$ 104,256	$ 104,256	24

Facility Name: St. Clair Supportive Living, LP **Report Period Beginning:** 12/01/2011 **Ending:** 2/31/2011

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	/ /	$ 10,338,000	$ 8,022,360	12/1/49	0.0580	$ 189,113	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	$ 9,678,611			$ 189,113	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 11,994,251	$ 9,678,611			$ 189,113	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: St. Clair Supportive Living, LP **Report Period Beginning:** 12/01/2011 **Ending:** 12/31/2011

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,167	$ 69,167	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	202,207	202,207	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	802	802	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 272,176	$ 272,176	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	9,163,247	9,163,247	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,148,373	2,148,373	16
17	Accumulated Depreciation (book methods)	(218,796)	(218,796)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,680	61,680	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,056,165	1,056,165	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,510,669	$ 12,510,669	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,782,845	$ 12,782,845	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 284,873	$ 284,873	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	900	900	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	38,761	38,761	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)**	$ 324,534	$ 324,534	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	8,022,360	8,022,360	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to affiliate	2,182,243	2,182,243	42
43				43
44	**TOTAL Long-Term Liabilities (sum of lines 38 thru 43)**	$ 11,860,854	$ 11,860,854	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 12,185,388	$ 12,185,388	45
46	**TOTAL EQUITY**	$ 597,457	$ 597,457	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 12,782,845	$ 12,782,845	47

***(See instructions.)**

Facility Name: St. Clair Supportive Living, LP **Report Period Beginning: 12/01/2011 Ending: 12/31/2011**

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	$ 464,045	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 464,045	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	175	8
9	Non-Resident Meals	4,141	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 4,316	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	5,774	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 5,774	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)**	$ 474,135	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	233,288	19
20	Health Care/ Personal Care	191,930	20
21	General Administration	610,577	21
	B. Capital Expense		
22	Ownership	421,277	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)**	$ 1,457,072	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (982,937)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (982,937)	31