

		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.

<p>I. Facility ID Number: <u>1000037</u></p> <p>Facility Name: <u>Knollwood Retirement Center</u></p> <p>Address: <u>20 Jacksonville Pl</u> <u>Jacksonville</u> <u>62650</u> <small>Number City Zip Code</small></p> <p>County: <u>Morgan</u></p> <p>Telephone Number: (<u>217</u>) <u>245-5101</u> Fax # <u>217 245-2000</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>11/03/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles W. Fawcett, Jr.</u> Telephone Number: (<u>636</u>) <u>537-5900</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/2014</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Charles W. Fawcett, Jr.</u> (Title) <u>President of General Partner</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Charles W. Fawcett, Jr.</u> (Title) <u>President of General Partner</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____
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Facility Name Jacksonville Assisted Living, L.P.

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	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	82	Single Unit Apartment	82	29,930	1
2	4	Double Unit Apartment	4	1,460	2
3		Other			3
4	86	TOTALS	86	31,390	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	19,442	10,930		30,372	5
6	Double Unit					6
7	Other					7
8	TOTALS	19,442	10,930		30,372	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.76%

D. Indicate the number of paid bed-hold days the SLF had during this year 234 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 38 (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

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES NO

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/14 Fiscal Year: 12/14

* 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: Jacksonville Assisted Living, L.P.

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 1	Supplies 2	Other 3	Total 4			
A. General Services								
1	Dietary and Food Purchase	256,135	25,165	211,145	492,445		492,445	1
2	Housekeeping, Laundry and Maintenance	139,676	109,565	32,478	281,719		281,719	2
3	Heat and Other Utilities			104,892	104,892		104,892	3
4	Other (specify):							4
5	TOTAL General Services	395,811	134,730	348,515	879,056		879,056	5
B. Health Care and Programs								
6	Health Care/ Personal Care	410,215	7,378	3,328	420,921		420,921	6
7	Activities and Social Services	53,400	22,110	304	75,814		75,814	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	463,615	29,488	3,632	496,735		496,735	9
C. General Administration								
10	Administrative and Clerical	249,542	16,008	586,136	851,686		851,686	10
11	Marketing Materials, Promotions and Advertising			35,633	35,633		35,633	11
12	Employee Benefits and Payroll Taxes			161,643	161,643		161,643	12
13	Insurance-Property, Liability and Malpractice			51,664	51,664		51,664	13
14	Other (specify): Mortgage Premium			33,756	33,756		33,756	14
15	TOTAL General Administration	249,542	16,008	868,832	1,134,382		1,134,382	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,108,968	180,226	1,220,979	2,510,173		2,510,173	16
Capital Expenses								
D. Ownership								
17	Depreciation & Amortization			219,845	219,845		219,845	17
18	Interest			285,319	285,319		285,319	18
19	Real Estate Taxes			51,635	51,635		51,635	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			556,799	556,799		556,799	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,108,968	180,226	1,777,778	3,066,972		3,066,972	24

Facility Name: Jacksonville Assisted Living, L.P.

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	\$ 19.25	1
2	Licensed Practical Nurses	3	17.45	2
3	Certified Nurse Assistants	10	9.80	3
4	Activity Director & Assistants	2	12.00	4
5	Social Service Workers Dan	1	25.00	5
6	Head Cook	3	10.50	6
7	Cook Helpers/Assistants	10	8.40	7
8	Dishwashers	3	8.25	8
9	Maintenance Workers	2	13.85	9
10	Housekeepers	4	8.50	10
11	Laundry HSK Manager	1	11.00	11
12	Managers ADM	1	36.06	12
13	Other Administrative	1	17.91	13
14	Clerical	4	9.92	14
15	Marketing	1	19.23	15
16	Other Dietary Manager	1	17.31	16
17	Total (lines 1 thru 16)	47	\$ 11.73	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	\$	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

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 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: Jacksonville Assisted Living, L.P.

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 500,000 Year land was acquired 2004

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			2004	2004	\$ 8,121,402	\$ 203,038		\$ 203,038	\$	\$ 2,165,738	1
2			2004	2004	485,883					484,853	2
3			2004	2004	66,860	6,686		6,686		71,317	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)				\$ 8,674,145	\$ 209,724		\$ 209,724	\$	\$ 2,721,908	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	84,429	3,786	3,786			81,100	19
20	TOTAL (lines 18 and 19)	\$ 84,429	\$ 3,786	\$ 3,786	\$		\$ 81,100	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	Off Equip	\$ 70,667	\$ \$ 2,619	\$ \$ 65,013	21
22	Bld Equip	67,474	608	64,925	22
23	Furnishings	144,685	(252)	144,686	23
24	TOTALS (lines 21, 22 and 23)	\$ 282,826	\$ 2,975	\$ 274,624	24

Facility Name: Jacksonville Assisted Living, L.P.

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 105,265	\$ 105,265	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	375,200	375,200	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,706	51,706	6
7	Other Prepaid Expenses	3,846	3,846	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 536,017	\$ 536,017	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	500,000	500,000	13
14	Buildings, at Historical Cost	8,674,145	8,674,145	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	367,255	367,255	16
17	Accumulated Depreciation (book methods)	(3,077,632)	(3,077,632)	17
18	Deferred Charges	97,861	97,861	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	602,795	602,795	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,164,424	\$ 7,164,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,700,441	\$ 7,700,441	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 126,341	\$ 126,341	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	51,635	51,635	31
32	Accrued Interest Payable	25,496	25,496	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)	\$ 203,472	\$ 203,472	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	153,108	153,108	38
39	Mortgage Payable	6,661,422	6,661,422	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)	\$ 6,814,530	\$ 6,814,530	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,018,002	\$ 7,018,002	45
46	TOTAL EQUITY	\$ 682,439	\$ 682,439	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,700,441	\$ 7,700,441	47

*(See instructions.)

Facility Name: Jacksonville Assisted Living, L.P.

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.)

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,783,237	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,783,237	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	1,045	8
9	Non-Resident Meals	8,244	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 9,289	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	1,743	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 1,743	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)	\$ 2,794,269	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	879,056	19
20	Health Care/ Personal Care	496,735	20
21	General Administration	1,134,382	21
B. Capital Expense			
22	Ownership	556,799	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)	\$ 3,066,972	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (272,703)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (272,703)	31

