

		FOR BHF USE			

b

Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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.</p> <p>Facility Name: <u>Knollwood Retirement Center</u></p> <p>Address: <u>20 Jacksonville Place</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: <u>74-2976993</u></p> <p>Date Current Owners were Certified: <u>11/03/05</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input checked="" type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></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>(636-537-5900)</u></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>01/01/07</u> to <u>12/31/07</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 border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Charles W. Fawcett, Jr.</u> (Title) <u>President of General Partner</u></td> </tr> <tr> <td style="width:50%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="center">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) () _____ Fax # () _____
<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 _____																												
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) () _____ Fax # () _____																												

Facility Name **Knollwood Retirement Center**

Report Period Beginning: **01/01/07** Ending: **12/31/07**

III. STATISTICAL DATA

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

Date of change in certified units 12/31/07

	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	2,920	2
3		Other			3
4	86	TOTALS	86	32,850	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	17,672	11,589		29,261	5
6	Double Unit		1,825		1,825	6
7	Other					7
8	TOTALS	17,672	13,414		31,086	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.63%

D. Indicate the number of paid bed-hold days the SLF had during this year 542 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 66 (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)

None

H. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/07 Fiscal Year: 12/07

* 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 Retirement Center

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	165,755	12,560	161,674	339,989		339,989	1
2	Housekeeping, Laundry and Maintenance	137,260	19,200	28,358	184,818		184,818	2
3	Heat and Other Utilities			93,765	93,765		93,765	3
4	Other (specify): Contract Services			26,460	26,460		26,460	4
5	TOTAL General Services	303,015	31,760	310,257	645,032		645,032	5
B. Health Care and Programs								
6	Health Care/ Personal Care	335,808	2,204	1,257	339,269		339,269	6
7	Activities and Social Services	66,804	13,786	9,685	90,275		90,275	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	402,612	15,990	10,942	429,544		429,544	9
C. General Administration								
10	Administrative and Clerical	218,085	5,074	259,020	482,179		482,179	10
11	Marketing Materials, Promotions and Advertising		5,028	6,917	11,945		11,945	11
12	Employee Benefits and Payroll Taxes			145,940	145,940		145,940	12
13	Insurance-Property, Liability and Malpractice			56,167	56,167		56,167	13
14	Other (specify): Mortgage Insurance			34,454	34,454		34,454	14
15	TOTAL General Administration	218,085	10,102	502,498	730,685		730,685	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	923,712	57,852	823,697	1,805,261		1,805,261	16
Capital Expenses								
D. Ownership								
17	Depreciation			363,293	363,293		363,293	17
18	Interest			459,100	459,100		459,100	18
19	Real Estate Taxes			72,929	72,929		72,929	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Amortization			5,576	5,576		5,576	22
23	TOTAL Ownership			900,898	900,898		900,898	23
24	GRAND TOTAL (Sum of lines 16 and 23)	923,712	57,852	1,724,595	2,706,159		2,706,159	24

Facility Name: Knollwood Retirement Center

Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 20.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	12	9.55	3
4	Activity Director & Assistants	2	11.50	4
5	Social Service Workers			5
6	Head Cook	2	8.50	6
7	Cook Helpers/Assistants	2	7.75	7
8	Dishwashers	3	7.50	8
9	Maintenance Workers	1	12.50	9
10	Housekeepers	5	8.50	10
11	Laundry	1	8.00	11
12	Managers	1	28.25	12
13	Other Administrative	1	17.00	13
14	Clerical	4	9.00	14
15	Marketing	1	16.75	15
16	Other (Driver)	1	1.00	16
17	Total (lines 1 thru 16)	38	\$ 10.57	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	None			\$	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: Knollwood Retirement Center

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 203,035	40	\$ 203,035	\$	\$ 744,462	1
2			2004	2004	485,883	97,692	5	97,692		357,344	2
3			2004	2004	66,860	6,686	10	6,686		24,515	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	\$ 307,413		\$ 307,413	\$	\$ 1,126,321	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	60,815	12,163	12,163		5	46,591	19
20	TOTAL (lines 18 and 19)	\$ 60,815	\$ 12,163	\$ 12,163	\$		\$ 46,591	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 2004-6	\$ 56,356	\$ \$ 11,283	\$ \$ 39,097	21
22	Bld Equip 2004	59,876	11,971	43,409	22
23	Furnishings 2004	143,381	20,463	74,936	23
24	TOTALS (lines 21, 22 and 23)	\$ 259,613	\$ 43,717	\$ 157,442	24

Facility Name: **Knollwood Retirement Center**

Report Period Beginning: **01/01/07**

Ending: **12/31/07**

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	2	3	4	5	6	
	Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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	2	3	4	6	7	8	9			
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	CAPMARK		X	Building	12/31/04	\$ 7,002,000	\$ 6,848,219	3/1/44	0.0655	\$ 449,918	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	Operations	9/1/05	525,000	475,208	8/1/20	0.0100	9,182	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 7,527,000	\$ 7,323,427			\$ 459,100	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 7,527,000	\$ 7,323,427			\$ 459,100	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 Retirement Center**Report Period Beginning: **01/01/07**

Ending:

12/31/07**12/31/07****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/07**

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 97,538	\$ 97,538	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	240,603	240,603	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,316	28,316	6
7	Other Prepaid Expenses	5,280	5,280	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 371,737	\$ 371,737	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	320,428	320,428	16
17	Accumulated Depreciation (book methods)	(1,330,354)	(1,330,354)	17
18	Deferred Charges	113,680	113,680	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	484,749	484,749	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,762,648	\$ 8,762,648	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,134,385	\$ 9,134,385	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 203,607	\$ 203,607	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	500	500	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	40,944	40,944	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)	\$ 245,051	\$ 245,051	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	475,208	475,208	38
39	Mortgage Payable	6,848,219	6,848,219	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Developer Fee Payable	758,837	758,837	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 8,082,264	\$ 8,082,264	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 8,327,315	\$ 8,327,315	45
46	TOTAL EQUITY	\$ 807,070	\$ 807,070	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 9,134,385	\$ 9,134,385	47

*(See instructions.)

Facility Name: Knollwood Retirement Center

Report Period Beginning: 01/01/07

Ending:

12/31/07

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

	1	Amount	
Revenue			
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,423,653	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,423,653	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	4,317	8
9	Non-Resident Meals	17,135	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 21,452	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	10,960	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 10,960	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)	\$ 2,456,065	18

	2	Amount	
Expenses			
A. Operating Expenses			
19	General Services	645,032	19
20	Health Care/ Personal Care	429,544	20
21	General Administration	730,685	21
B. Capital Expense			
22	Ownership	900,898	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)	\$ 2,706,159	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (250,094)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (250,094)	31

Jacksonville Assisted Living, LP
Report Period 01/01/07 - 12/31/07
Section VII, C

<u>Related Party Name</u>	<u>Amount Paid</u>	<u>Reason</u>
Knollwood Management Services	120,034.35	Management Fees
Fawcett Corporation	384.72	Office supplies, postage, travel exp.
Knollwood Development Corp.	4,456.00	Developer/Audit fees