

		FOR BHF USE			

LL2

Supportive Living Facility

**2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2012)**

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 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: _____</p> <p>Date Current Owners were Certified: <u>11/03/05</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) 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>01/01/2012</u> to <u>12/31/2012</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Charles W. Fawcett, Jr.</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President of General Partner</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) () _____</td> <td>Fax # () _____</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) _____	(Date) _____		(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 # () _____
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	(Telephone) () _____	Fax # () _____																																												

Facility Name _____

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

Date of change in certified units 12/31/12

	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	30,012	1
2	4	Double Unit Apartment	4	2,928	2
3		Other			3
4	86	TOTALS	86	32,940	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	16,662	12,852		29,514	5
6	Double Unit		366		366	6
7	Other			5	5	7
8	TOTALS	16,662	13,218	5	29,885	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.73%

D. Indicate the number of paid bed-hold days the SLF had during this year 461 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 107 (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: 12/12 Fiscal Year: 12/12

* 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:

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

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	244,907	24,249	197,507	466,663		466,663	1
2	Housekeeping, Laundry and Maintenance	127,829	26,881	45,273	199,983		199,983	2
3	Heat and Other Utilities			75,385	75,385		75,385	3
4	Other (specify): Outside Labor			37,438	37,438		37,438	4
5	TOTAL General Services	372,736	51,130	355,603	779,469		779,469	5
B. Health Care and Programs								
6	Health Care/ Personal Care	377,278	5,279	657	383,214		383,214	6
7	Activities and Social Services	36,352	15,629	2,863	54,844		54,844	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	413,630	20,908	3,520	438,058		438,058	9
C. General Administration								
10	Administrative and Clerical	235,565	7,159	369,274	611,998		611,998	10
11	Marketing Materials, Promotions and Advertising			27,734	27,734		27,734	11
12	Employee Benefits and Payroll Taxes			184,887	184,887		184,887	12
13	Insurance-Property, Liability and Malpractice			37,757	37,757		37,757	13
14	Other (specify): Mortgage Premium			33,024	33,024		33,024	14
15	TOTAL General Administration	235,565	7,159	652,676	895,400		895,400	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,021,931	79,197	1,011,799	2,112,927		2,112,927	16
Capital Expenses								
D. Ownership								
17	Depreciation & Amortization			222,036	222,036		222,036	17
18	Interest			287,774	287,774		287,774	18
19	Real Estate Taxes			49,258	49,258		49,258	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			559,068	559,068		559,068	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,021,931	79,197	1,570,867	2,671,995		2,671,995	24

Facility Name:

Report Period Beginning 01/01/2012 Ending: 12/31/2012

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	\$ 23.00	1
2	Licensed Practical Nurses	3	17.25	2
3	Certified Nurse Assistants	10	9.60	3
4	Activity Director & Assistants	1	14.50	4
5	Social Service Workers			5
6	Head Cook	3	8.98	6
7	Cook Helpers/Assistants	11	8.35	7
8	Dishwashers	3	8.25	8
9	Maintenance Workers	1	14.00	9
10	Housekeepers	4	8.50	10
11	Laundry	1	10.40	11
12	Managers	1	36.06	12
13	Other Administrative	1	17.31	13
14	Clerical	3	9.86	14
15	Marketing	1	19.23	15
16	Other	1	16.83	16
17	Total (lines 1 thru 16)	47	\$ 11.68	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

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:

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	\$ 200,613	40	\$ 200,613	\$	\$ 1,759,662	1
2			2004	2004	485,883		5			484,853	2
3			2004	2004	66,860	6,686	10	6,686		57,945	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	\$ 207,299		\$ 207,299	\$	\$ 2,302,460	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	8,112	8,112		5	74,159	19
20	TOTAL (lines 18 and 19)	\$ 84,429	\$ 8,112	\$ 8,112	\$		\$ 74,159	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	\$ 64,991	\$ 1,470	\$ 60,924	21
22	Bld Equip	65,050	1,109	63,208	22
23	Furnishings	144,685	686	144,252	23
24	TOTALS (lines 21, 22 and 23)	\$ 274,726	\$ 3,265	\$ 268,384	24

Facility Name:

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 144,965	\$ 144,965	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	528,802	528,802	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,087	23,087	6
7	Other Prepaid Expenses	31,245	31,245	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 728,099	\$ 728,099	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	359,156	359,156	16
17	Accumulated Depreciation (book methods)	(2,645,003)	(2,645,003)	17
18	Deferred Charges	104,580	104,580	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	619,866	619,866	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,612,744	\$ 7,612,744	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,340,843	\$ 8,340,843	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 128,189	\$ 128,189	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,509	4,509	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	50,908	50,908	31
32	Accrued Interest Payable	26,276	26,276	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)	\$ 209,882	\$ 209,882	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	234,588	234,588	38
39	Mortgage Payable	6,881,814	6,881,814	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)	\$ 7,116,402	\$ 7,116,402	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,326,284	\$ 7,326,284	45
46	TOTAL EQUITY	\$ 1,014,559	\$ 1,014,559	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 8,340,843	\$ 8,340,843	47

*(See instructions.)

Facility Name:

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

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	\$ 2,817,048	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,817,048	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	6,464	8
9	Non-Resident Meals	15,891	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 22,355	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	13,953	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 13,953	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)	\$ 2,853,356	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	779,469	19
20	Health Care/ Personal Care	438,058	20
21	General Administration	895,400	21
B. Capital Expense			
22	Ownership	559,068	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)	\$ 2,671,995	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 181,361	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 181,361	31

