

		FOR BHF USE			

LL2

Supportive Living Facility

**2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)**

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>1000130</u></p> <p>Facility Name: <u>Knollwood St Clair Ret Comm</u></p> <hr/> <p>Address: <u>921 Knollwood Drive</u> <u>Caseyville</u> <u>62232</u></p> <p align="center">Number City Zip Code</p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: (<u>618</u>) <u>395-0569</u> Fax # (<u>618</u>) <u>394-0582</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>04/30/11</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>01/01/2017</u> to <u>12/31/2017</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) (<u> </u>) _____</td> <td>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) _____	(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) (<u> </u>) _____	Fax # (<u> </u>) _____
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	(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____																																												

Facility Name Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

Date of change in certified units 12/31/16

	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	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 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	29,119	3,999		33,118	5
6	Double Unit	451	451		902	6
7	Other					7
8	TOTALS	29,570	4,450		34,020	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 95.11%

D. Indicate the number of paid bed-hold days the SLF had during this year 327 Also, indicate the number of unpaid bed-hold days the SLF had during this year. None (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: 12/2017 Fiscal Year: 12/2017

* 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? _____
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:

01/01/2017

Ending: 12/31/2017

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	226,007	201,893	8,339	436,239		436,239	1
2	Housekeeping, Laundry and Maintenance	176,517	72,043	919	249,479		249,479	2
3	Heat and Other Utilities			109,782	109,782		109,782	3
4	Other (specify):							4
5	TOTAL General Services	402,524	273,936	119,040	795,500		795,500	5
B. Health Care and Programs								
6	Health Care/ Personal Care	354,286	7,104	2,208	363,598		363,598	6
7	Activities and Social Services	37,738	15,494	6,325	59,557		59,557	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	392,024	22,598	8,533	423,155		423,155	9
C. General Administration								
10	Administrative and Clerical	188,796	10,408	308,461	507,665		507,665	10
11	Marketing Materials, Promotions and Advertising	49,125		23,639	72,764		72,764	11
12	Employee Benefits and Payroll Taxes			146,527	146,527		146,527	12
13	Insurance-Property, Liability and Malpractice			97,226	97,226		97,226	13
14	Other (specify): (Mortgage Insurance Premium)			44,400	44,400		44,400	14
15	TOTAL General Administration	237,921	10,408	620,253	868,582		868,582	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,032,469	306,942	747,826	2,087,237		2,087,237	16
Capital Expenses								
D. Ownership								
17	Depreciation			313,786	313,786		313,786	17
18	Interest			359,477	359,477		359,477	18
19	Real Estate Taxes			66,100	66,100		66,100	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			739,363	739,363		739,363	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,032,469	306,942	1,487,189	2,826,600		2,826,600	24

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.00	1
2	Licensed Practical Nurses	2	18.50	2
3	Certified Nurse Assistants	9	10.00	3
4	Activity Director & Assistants	2	12.00	4
5	Social Service Workers	1	27.16	5
6	Head Cook	3	10.30	6
7	Cook Helpers/Assistants	6	8.50	7
8	Dishwashers	2	8.25	8
9	Maintenance Workers	2	11.68	9
10	Housekeepers	4	8.80	10
11	Laundry	1	18.03	11
12	Managers	1	31.25	12
13	Other Administrative	1	20.19	13
14	Clerical	5	10.29	14
15	Marketing	1	16.83	15
16	Other	1	16.35	16
17	Total (lines 1 thru 16)	42	\$ 15.05	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	N/A	\$ 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		Man. Services	

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 St Clair Ret Comm

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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	\$ 10,637,290	\$ 304,290	40	\$ 304,290	\$	\$ 1,970,038	1
2			2012	2012	102	102	40	102		7,646	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)				\$ 10,637,392	\$ 304,392		\$ 304,392	\$	\$ 1,977,684	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	Furn., Fixtures & Equip.	\$ 688,373	\$ 2,550	\$ 678,265	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 688,373	\$ 2,550	\$ 678,265	24

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 17,187	\$ 17,187	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	733,822	733,822	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,381	48,381	6
7	Other Prepaid Expenses	26,916	26,916	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 826,306	\$ 826,306	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	688,373	688,373	16
17	Accumulated Depreciation (book methods)	(2,655,949)	(2,655,949)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	895,693	895,693	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Loan Costs	218,424	218,424	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,147,835	\$ 10,147,835	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,974,141	\$ 10,974,141	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 375,760	\$ 375,760	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	29,151	29,151	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)	\$ 404,911	\$ 404,911	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	9,716,912	9,716,912	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)	\$ 11,373,163	\$ 11,373,163	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,778,074	\$ 11,778,074	45
46	TOTAL EQUITY	\$ (803,933)	\$ (803,933)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,974,141	\$ 10,974,141	47

*(See instructions.)

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2017

Ending:

12/31/2017

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

		1	
I. Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 3,110,373	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,110,373	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	674	8
9	Non-Resident Meals	10,970	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 11,644	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	2,335	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,335	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)	\$ 3,124,352	18

		2	
II. Expenses		Amount	
A. Operating Expenses			
19	General Services	795,500	19
20	Health Care/ Personal Care	423,155	20
21	General Administration	868,582	21
B. Capital Expense			
22	Ownership	739,363	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)	\$ 2,826,600	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 297,752	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 297,752	31
III. Net Resident Care Revenue detailed by Payer Source			
32	Medicaid - Net Inpatient Revenue	\$ 2,688,283	32
33	Private Pay - Net Inpatient Revenue	322,838	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamp</u>	99,252	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,110,373	37