FOR BHF USE

LL2

Supportive Living Facility

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2018)

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 ID Number: 1000130

Facility Name: Knollwood St Clair Ret Comm

Address: 921 Knollwood Drive (Number) Caseyville (City) 62232 (Zip Code)

County: St. Clair

Telephone Number: # 618) 395-0569 **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 01/01/2018 to 12/31/2018 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 Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units 12/31/16

	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	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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	28,420	3,647		32,067	5
6	Double Unit	542	99		641	6
7	Other					7
8	TOTALS	28,962	3,746		32,708	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.44%

D. Indicate the number of paid bed-hold days the SLF had during this year 511 **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 [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: 12/2018 Fiscal Year: 12/2018
* 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 principal?** 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 principal?**
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 principal?**
If no, explain.

Facility Name: Knollwood St Clair Ret Comm **Report Period Beginning: 01/01/2018 Ending: 12/31/2018**

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	213,811	200,869	3,566	418,246		418,246	1
2	Housekeeping, Laundry and Maintenance	171,397	64,195	74,056	309,648		309,648	2
3	Heat and Other Utilities			136,172	136,172		136,172	3
4	Other (specify):							4
5	**TOTAL General Services**	385,208	265,064	213,794	864,066		864,066	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	362,407	6,915	2,673	371,995		371,995	6
7	Activities and Social Services	45,603	8,756	10,159	64,518		64,518	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	408,010	15,671	12,832	436,513		436,513	9
	C. General Administration							
10	Administrative and Clerical	216,778	11,538	272,271	500,587		500,587	10
11	Marketing Materials, Promotions and Advertising	46,990		21,486	68,476		68,476	11
12	Employee Benefits and Payroll Taxes			171,346	171,346		171,346	12
13	Insurance-Property, Liability and Malpractice			78,857	78,857		78,857	13
14	Other (specify) (Mortgabe Insurance reium			42,018	42,018		42,018	14
15	**TOTAL General Administration**	263,768	11,538	585,978	861,284		861,284	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,056,986	292,273	812,604	2,161,863		2,161,863	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			314,546	314,546		314,546	17
18	Interest			362,759	362,759		362,759	18
19	Real Estate Taxes			56,963	56,963		56,963	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			734,268	734,268		734,268	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,056,986	292,273	1,546,872	2,896,131		2,896,131	24

Facility Name: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 27.88	1
2	Licensed Practical Nurses	2	19.00	2
3	Certified Nurse Assistants	5	10.00	3
4	Activity Director & Assistants	3	12.00	4
5	Diet Manager	1	16.85	5
6	Head Cook	2	9.65	6
7	Cook Helpers/Assistants	4	8.25	7
8	Dishwashers	1	8.25	8
9	Maintenance Workers	2	10.50	9
10	Housekeepers	3	8.25	10
11	Laundry	1	8.25	11
12	Managers Hsekeeping	1	18.00	12
13	Other Administrative	1	31.25	13
14	Clerical	2	16.75	14
15	Marketing	1	26.90	15
16	Other			16
17	Total (lines 1 thru 16)	30	13.10	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				OTHER RELATED BUSINESS ENTITIES				
Name	1	City	2	Name	3	City	4	Type of Business 5
N/A				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 [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: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 240,388	40	$ 240,388	$	$ 2,210,528	1
2			2012	2012	102		40			7,646	2
3			2017	2017	63,902	63,902	40 #	63,902		63,902	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)				$ 10,701,294	$ 304,290		$ 304,290	$	$ 2,282,076	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.	$ 688,737	$ $ 3,310	$ $ 681,575	21
22	.				22
23					23
24	TOTALS (lines 21, 22 and 23)	$ 688,737	$ 3,310	$ 681,575	24

Facility Name: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	Gershmqann		X	`Building	11/1/09	$ 10,338,000	$ 9,552,193	12/1/49	0.0360	$ 346,614	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	Building	12/1/09	1,656,251 `	` 1,656,251	12/3/51	None	`` None `	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 11,994,251	$ 11,208,444			$ 346,614	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 11,994,251	$ 11,208,444			$ 346,614	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 St Clair Ret Comm **Report Period Beginning:** 01/01/2018 **Ending:** 12/31/2018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 20,707	$ 20,707	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	835,330	835,330	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,175	42,175	6
7	Other Prepaid Expenses	30,533	30,533	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 928,745	$ 928,745	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)	(2,963,651)	(2,963,651)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	759,958	759,958	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Loan Costs	211,580	211,580	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,697,554	$ 9,697,554	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,626,299	$ 10,626,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 34,395	$ 34,395	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	28,657	28,657	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)**	$ 63,052	$ 63,052	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	9,552,193	9,552,193	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)**	$ 11,208,444	$ 11,208,444	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 11,271,496	$ 11,271,496	45
46	**TOTAL EQUITY**	$ (645,197)	$ (645,197)	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 10,626,299	$ 10,626,299	47

***(See instructions.)**

Facility Name: Knollwood St Clair Ret Comm Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,040,904	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,040,904	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	470	8
9	Non-Resident Meals	8,120	9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 8,590	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	5,373	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 5,373	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)**	$ 3,054,867	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	864,066	19
20	Health Care/ Personal Care	436,513	20
21	General Administration	861,284	21
	B. Capital Expense		
22	Ownership	734,268	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)**	$ 2,896,131	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 158,736	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 158,736	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 2,675,467	32
33	Private Pay - Net Inpatient Revenue	262,074	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) **Food Stamp**	103,363	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 3,040,904	37