

Facility Name St. Clair Supportive Living, LP

Report Period Beginning: 12/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

Date of change in certified units 12/31/11

	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	98	Single Unit Apartment	98	24,010	1
2		Double Unit Apartment			2
3		Other			3
4	98	TOTALS	98	24,010	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	3,450 #			4,817	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,450			4,817	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 20.06%

D. Indicate the number of paid bed-hold days the SLF had during this year 168 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 20 (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: 12/11 Fiscal Year: 12/11

* 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.

STATE OF ILLINOIS

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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	76,108	16,664	45,508	138,280		138,280	1
2	Housekeeping, Laundry and Maintenance	65,893	15,978	(20,630)	61,241		61,241	2
3	Heat and Other Utilities			33,767	33,767		33,767	3
4	Other (specify):							4
5	TOTAL General Services	142,001	32,642	58,645	233,288		233,288	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	173,662	5,277	2,343	181,282		181,282	6
7	Activities and Social Services	6,012		4,636	10,648		10,648	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	179,674	5,277	6,979	191,930		191,930	9
	C. General Administration							
10	Administrative and Clerical	76,404	22,429	185,812	284,645		284,645	10
11	Marketing Materials, Promotions and Advertising			168,812	168,812		168,812	11
12	Employee Benefits and Payroll Taxes			86,603	86,603		86,603	12
13	Insurance-Property, Liability and Malpractice			70,517	70,517		70,517	13
14	Other (specify): Mortgage Premium							14
15	TOTAL General Administration	76,404	22,429	511,744	610,577		610,577	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	398,079	60,348	577,368	1,035,795		1,035,795	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			232,165	232,165		232,165	17
18	Interest			189,112	189,112		189,112	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			421,277	421,277		421,277	23
24	GRAND TOTAL (Sum of lines 16 and 23)	398,079	60,348	998,645	1,457,072		1,457,072	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 23.80	1
2	Licensed Practical Nurses	1	17.00	2
3	Certified Nurse Assistants	10	9.50	3
4	Activity Director & Assistants	1	8.50	4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	4	8.25	7
8	Dishwashers-incl with cooh assist above			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	2	8.25	10
11	Laundry Hsk Manager	1	14.42	11
12	Managers Admin	1	36.06	12
13	Other Administrative	1	16.83	13
14	Clerical	2	10.00	14
15	Marketing			15
16	Other Dietary Mngr	1	20.00	16
17	Total (lines 1 thru 16)	27	\$ 12.00	17

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
Kno;wood Management Services		St. Louis		Management Compa	

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).

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

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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	\$ 9,163,247	\$ 114,540	40	\$ 114,540	\$	\$ 114,540	1
2											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)				\$ 9,163,247	\$ 114,540		\$ 114,540	\$	\$ 114,540	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					5		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	Furnishings & Fixtures	\$ 2,148,373	\$ \$ 104,256	\$ \$ 104,256	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 2,148,373	\$ 104,256	\$ 104,256	24

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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	Gershman		X	Building	/ /	\$ 10,338,000	\$ 8,022,360	12/1/49	0.0580	\$ 189,113	1
2					/ /						2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	Building	12/1/09	1,656,251	1,656,251	12/31/51	N/A	None	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,994,251	\$ 9,678,611			\$ 189,113	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,994,251	\$ 9,678,611			\$ 189,113	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 69,167	\$ 69,167	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	202,207	202,207	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	802	802	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 272,176	\$ 272,176	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	9,163,247	9,163,247	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,148,373	2,148,373	16
17	Accumulated Depreciation (book methods)	(218,796)	(218,796)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,680	61,680	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,056,165	1,056,165	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,510,669	\$ 12,510,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,782,845	\$ 12,782,845	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 284,873	\$ 284,873	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	900	900	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	38,761	38,761	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)	\$ 324,534	\$ 324,534	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	8,022,360	8,022,360	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to affiliate	2,182,243	2,182,243	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 11,860,854	\$ 11,860,854	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 12,185,388	\$ 12,185,388	45
46	TOTAL EQUITY	\$ 597,457	\$ 597,457	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 12,782,845	\$ 12,782,845	47

*(See instructions.)

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 464,045	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 464,045	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	175	8
9	Non-Resident Meals	4,141	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 4,316	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	5,774	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 5,774	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)	\$ 474,135	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	233,288	19
20	Health Care/ Personal Care	191,930	20
21	General Administration	610,577	21
	B. Capital Expense		
22	Ownership	421,277	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)	\$ 1,457,072	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (982,937)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (982,937)	31

