

		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: 1000037

Facility Name: Knollwood Retirement Center

Address: 20 Jacksonville Plc Jacksonville 62650

Number City Zip Code

County: Morgan

Telephone Number: # 217) 245-5101 Fax # 217 245-2000

Federal Employer ID Number:

Date Current Owners were Certified: 11/03/05

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☐ Charitable Corp.

☐ Trust

IRS Exemption Code

☐ PROPRIETARY

☐ Individual

☒ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other

☐ GOVERNMENTAL

☐ State

☐ County

☐ 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

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	82	Single Unit Apartment	82	29,930	1
2	4	Double Unit Apartment	4	1,460	2
3		Other			3
4	86	TOTALS	86	31,390	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	18,354	10,649		29,003	5
6	Double Unit		365		365	6
7	Other					7
8	TOTALS	18,354	11,014		29,368	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.56%

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 ☒

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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ 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. _____

STATE OF ILLINOIS

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Facility Name: Knollwood Retirement Center

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 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food	250,872	20,200	200,868	471,940		471,940	1
2	Housekeeping, Laundry and Maintenance	192,053	26,601	158,472	377,126		377,126	2
3	Heat and Other Utilities			110,826	110,826		110,826	3
4	Other (specify):							4
5	TOTAL General Services	442,925	46,801	470,166	959,892		959,892	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	392,437	5,173	3,123	400,733		400,733	6
7	Activities and Social Services	44,543	21,531	1,565	67,639		67,639	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	436,980	26,704	4,688	468,372		468,372	9
	C. General Administration							
10	Administrative and Clerical	278,475	10,550	283,299	572,324		572,324	10
11	Marketing Materials, Promotions and Advertising	51,750		7,368	59,118		59,118	11
12	Employee Benefits and Payroll Taxes			175,441	175,441		175,441	12
13	Insurance-Property, Liability and Malpractice			56,643	56,643		56,643	13
14	Other (specify): (Mortgage Insurance Premium)			13,097	13,097		13,097	14
15	TOTAL General Administration	330,225	10,550	535,848	876,623		876,623	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,210,130	84,055	1,010,702	2,304,887		2,304,887	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			237,389	237,389		237,389	17
18	Interest			620,194	620,194		620,194	18
19	Real Estate Taxes			104,049	104,049		104,049	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): (Incentive Supervisory Fee)			150,000	150,000		150,000	22
23	TOTAL Ownership			1,111,632	1,111,632		1,111,632	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,210,130	84,055	2,122,334	3,416,519		3,416,519	24

Facility Name: Knollwood Retirement Center

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	\$ 21.00	1
2	Licensed Practical Nurses	3	18.50	2
3	Certified Nurse Assistants	6	10.00	3
4	Activity Director & Assistants	1	16.50	4
5	Social Service Workers			5
6	Head Cook	2	15.00	6
7	Cook Helpers/Assistants	2	10.00	7
8	Dishwashers	2	8.25	8
9	Maintenance Workers	2	16.00	9
10	Housekeepers	2	8.25	10
11	Laundry	1	9.50	11
12	Managers	1	11.60	12
13	Other Administrative	1	36.00	13
14	Clerical	2	16.85	14
15	Marketing	1	19.23	15
16	Other			16
17	Total (lines 1 thru 16)	27	13.22	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
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).

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

Facility Name: Knollwood Retirement Center

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	\$ 206,279	40	\$ 206,279		\$ 3,540,701	1
2			2004	2004	485,883		5				2
3			2004	2004	66,860		10				3
4			2006	2006	62,685		10				4
5			2018	2018	8,586		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)				\$ 8,745,416	\$ 206,279		\$ 206,279		\$ 3,540,701	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						19
20	TOTAL (lines 18 and 19)	\$ 84,429	\$	\$	\$		\$ 84,429	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	Office Equip	\$ 79,230	\$ 3,073	\$ 75,527	21
22	Bld. Equip.	115,600	7,189	77,809	22
23	Furnishings	169,304	11,440	163,770	23
24	TOTALS (lines 21, 22 and 23)	\$ 364,134	\$ 21,702	\$ 317,106	24

Facility Name: Knollwood Retirement Center

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	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	Gershmann		X	Building	05/17/1/8	\$ 7,002,000	\$ 6,961,457	3/1/56	0.0396	\$ 532,414	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	Operations	6/4/05	525,000	None	/ /	0.0100	None	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 7,527,000	\$ 6,961,457			\$ 532,414	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 7,527,000	\$ 6,961,457			\$ 532,414	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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Facility Name: Knollwood Retirement Center

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	\$ 103,755	\$ 103,755	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	501,214	501,214	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,930	28,930	6
7	Other Prepaid Expenses	4,641	4,641	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 638,540	\$ 638,540	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	8,682,731	8,682,731	14
15	Leasehold Improvements, at Historical Cost	62,685	62,685	15
16	Equipment, at Historical Cost	453,133	453,133	16
17	Accumulated Depreciation (book methods)	(3,942,236)	(3,942,236)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	745,686	745,686	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,501,999	\$ 6,501,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,140,539	\$ 7,140,539	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 141,880	\$ 141,880	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	91,042	91,042	31
32	Accrued Interest Payable	22,672	22,672	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)	\$ 255,594	\$ 255,594	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	6,961,457	6,961,457	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)	\$ 6,961,457	\$ 6,961,457	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 7,217,051	\$ 7,217,051	45
46	TOTAL EQUITY	\$ (76,512)	\$ (76,512)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,140,539	\$ 7,140,539	47

*(See instructions.)

Facility Name: Knollwood Retirement Center

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.)

1			
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,831,516	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,831,516	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	588	8
9	Non-Resident Meals	9,630	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 10,218	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	9,337	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 9,337	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)	\$ 2,851,071	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	959,892	19
20	Health Care/ Personal Care	468,372	20
21	General Administration	876,623	21
	B. Capital Expense		
22	Ownership	1,111,632	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)	\$ 3,416,519	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (565,448)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (565,448)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,610,705	32
33	Private Pay - Net Inpatient Revenue	1,220,811	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,831,516	37