

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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 Village Road Caseyville 62232

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

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 01/01/2019 to 12/31/2019 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)

(Type or Print Name) Charles W Fawcett Jr

(Title) President of General Partner

Paid Preparer

(Signed)

(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

HFS 3745C (N-4-05)

IL478-2471

III. STATISTICAL DATA

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

Date of change in certified units 12/31/19

	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	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	28,191	1,934		30,125	5
6	Double Unit	71			71	6
7	Other					7
8	TOTALS	28,262	1,934		30,196	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 84.42%

D. Indicate the number of paid bed-hold days the SLF had during this year

337 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 18 (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: 12/2019 Fiscal Year: 12/2019

* 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 St Clair Ret Comm

Report Period Beginning:

01/01/2019

Ending:

12/31/2019

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	239,186	211,582	2,883	453,651		453,651	1
2	Housekeeping, Laundry and Maintenance	182,923	36,569	77,552	297,044		297,044	2
3	Heat and Other Utilities			140,678	140,678		140,678	3
4	Other (specify): Telephone, cable, internet			51,660	51,660		51,660	4
5	TOTAL General Services	422,109	248,151	272,773	943,033		943,033	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	398,024	16,852	3,991	418,867		418,867	6
7	Activities and Social Services	64,438	7,961	3,865	76,264		76,264	7
8	Other (specify): Driver/Nursing Equip repairs	13,056		7,929	20,985		20,985	8
9	TOTAL Health Care and Programs	475,518	24,813	15,785	516,116		516,116	9
	C. General Administration							
10	Administrative and Clerical	214,618	14,717	281,744	511,079		511,079	10
11	Marketing Materials, Promotions and Advertising	30,869		7,961	38,830		38,830	11
12	Employee Benefits and Payroll Taxes			182,598	182,598		182,598	12
13	Insurance-Property, Liability and Malpractice			80,432	80,432		80,432	13
14	Other (specify): Mortgage Ins			42,117	42,117		42,117	14
15	TOTAL General Administration	245,487	14,717	594,852	855,056		855,056	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,143,114	287,681	883,410	2,314,205		2,314,205	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			313,540	313,540		313,540	17
18	Interest			356,713	356,713		356,713	18
19	Real Estate Taxes			56,799	56,799		56,799	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			727,052	727,052		727,052	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,143,114	287,681	1,610,462	3,041,257		3,041,257	24

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2019 Ending: 12/31/2019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 24.00	1
2	Licensed Practical Nurses	3	19.50	2
3	Certified Nurse Assistants	8	11.00	3
4	Activity Director & Assistants	2	13.00	4
5	Social Service Workers	1	16.85	5
6	Head Cook	3	12.10	6
7	Cook Helpers/Assistants	4	9.30	7
8	Dishwashers	1	9.25	8
9	Maintenance Workers	2	13.50	9
10	Housekeepers	3	9.50	10
11	Laundry	1	9.50	11
12	Managers	1	18.03	12
13	Other Administrative	1	29.81	13
14	Clerical	4	14.11	14
15	Marketing	1	21.63	15
16	Other			16
17	Total (lines 1 thru 16)	36	\$ 13.53	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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

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		\$	1
2			2
Total		\$	3

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	\$ 250,646	40	\$ 250,646	\$	\$ 2,514,920	1
2			2012	2012	102					7,646	2
3			2017	2017	63,902	51,556		51,556		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	\$ 302,202		\$ 302,202	\$	\$ 2,586,468	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	\$ \$ 4,494	\$ \$ 683,879	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$ 688,373	\$ 4,494	\$ 683,879	24

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2019 Ending: 2/31/2019

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	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	11/1/09	\$ 10,338,000	\$ 9,381,446	12/1/49	0.0360	\$ 340,568	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	\$ 11,037,697			\$ 340,568	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 11,994,251	\$ 11,037,697			\$ 340,568	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: 01/01/2019

Ending: 12/31/2019

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2019

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 60,873	\$ 60,873	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,018,780	1,018,780	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,175	42,175	6
7	Other Prepaid Expenses	30,513	30,513	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,152,341	\$ 1,152,341	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)	(3,270,347)	(3,270,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	695,801	695,801	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	204,736	204,736	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,319,857	\$ 9,319,857	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,472,198	\$ 10,472,198	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 79,578	\$ 79,578	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	28,144	28,144	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)	\$ 107,722	\$ 107,722	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	9,381,446	9,381,446	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)	\$ 11,037,697	\$ 11,037,697	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,145,419	\$ 11,145,419	45
46	TOTAL EQUITY	\$ (673,221)	\$ (673,221)	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 10,472,198	\$ 10,472,198	47

*(See instructions.)

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 01/01/2019

Ending:

12/31/2019

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	\$ 2,992,991	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,992,991	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	401	8
9	Non-Resident Meals	9,993	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 10,394	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	9,857	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 9,857	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)	\$ 3,013,242	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	943,033	19
20	Health Care/ Personal Care	516,116	20
21	General Administration	855,056	21
	B. Capital Expense		
22	Ownership	727,052	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)	\$ 3,041,257	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (28,015)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (28,015)	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,675,412	32
33	Private Pay - Net Inpatient Revenue	198,421	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food stamps</u>	119,158	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,992,991	37