

		FOR BHF USE			

LL2

Supportive Living Facility

2021

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2021)

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 Caseyville 62232

County: St Clair

Telephone Number: (618) 394-0569 Fax # 618 394-0582

Federal Employer ID Number:

Date Current Owners were Certified: 4/30/2011

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

X 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: Larry Templin Telephone Number: (630) 361-2868

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 1/1/21 to 12/31/21 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) Linda Baker

(Title) General Partner

Paid Preparer

(Signed) SEE ACCOUNTANT'S COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 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

Facility Name Knollwood St Clair Ret Comm Report Period Beginning: 1/1/21 Ending: 12/31/21

III. STATISTICAL DATA

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

Date of change in certified units N/A

	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	365	2
3		Other		334	3
4	98	TOTALS	98	35,739	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	25,223	1,852		27,075	# 5
6	Double Unit	334			334	6
7	Other	334			334	7
8	TOTALS	25,891	1,852		27,743	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 77.63%

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

None Also, indicate the number of unpaid bed-hold days the SLF had during this year. 384 (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)

None

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 12/31/21 Fiscal Year: 12/31/21

* 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. N/A

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? N/A

If no, explain. N/A

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? N/A

If no, explain. N/A

STATE OF ILLINOIS

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Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning:

1/1/21

Ending:

12/31/21

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	216,843	232,727	2,835	452,405	(6,861)	445,544	1
2	Housekeeping, Laundry and Maintenance	190,803	36,800	144,930	372,533		372,533	2
3	Heat and Other Utilities			123,941	123,941		123,941	3
4	Other (specify): Trash Expense			10,245	10,245		10,245	4
5	TOTAL General Services	407,646	269,527	281,951	959,124	(6,861)	952,263	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	450,801	21,645	4,557	477,003		477,003	6
7	Activities and Social Services	17,807	4,336	1,350	23,493		23,493	7
8	Other (specify): Driver	10,290			10,290		10,290	8
9	TOTAL Health Care and Programs	478,898	25,981	5,907	510,786		510,786	9
	C. General Administration							
10	Administrative and Clerical	281,830	17,211	530,273	829,314	(336,729)	492,585	10
11	Marketing Materials, Promotions and Advertising	61,869		35,376	97,245		97,245	11
12	Employee Benefits and Payroll Taxes			185,009	185,009		185,009	12
13	Insurance-Property, Liability and Malpractice			110,652	110,652		110,652	13
14	Other (specify):							14
15	TOTAL General Administration	343,699	17,211	861,310	1,222,220	(336,729)	885,491	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,230,243	312,719	1,149,168	2,692,130	(343,590)	2,348,540	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			306,696	306,696	(1,263)	305,433	17
18	Interest			263,444	263,444	(3,463)	259,981	18
19	Real Estate Taxes			57,600	57,600		57,600	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			13,896	13,896		13,896	21
22	Other (specify): See Attached Sch I			43,544	43,544		43,544	22
23	TOTAL Ownership			685,180	685,180	(4,726)	680,454	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,230,243	312,719	1,834,348	3,377,310	(348,316)	3,028,994	24

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning 1/1/21 Ending: 12/31/21

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.25	\$ 26.35	1
2	Licensed Practical Nurses	3.00	24.90	2
3	Certified Nurse Assistants	8.25	12.80	3
4	Activity Director & Assistants	1.00	13.66	4
5	Social Service Workers			5
6	Head Cook	3.25	14.13	6
7	Cook Helpers/Assistants	5.00	11.00	7
8	Dishwashers			8
9	Maintenance Workers	1.50	15.47	9
10	Housekeepers	5.25	12.61	10
11	Laundry			11
12	Managers	1.00	29.80	12
13	Other Administrative	5.00	15.30	13
14	Clerical	1.00	22.20	14
15	Marketing	1.00	23.60	15
16	Other			16
17	Total (lines 1 thru 16)	36.50	\$ 15.30	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
Knollwood Management Services		Caseyville, IL		Management	

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: N/A If yes, what is the value of those services? \$ N/A

(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	See Attached Schedule I			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	None	\$	1
2			2
Total		\$	3

Facility Name: Knollwood St Clair Ret Comm

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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	\$ 10,637,290	\$ 305,087	40	\$ 305,087		\$ 3,070,653	1
2			2012	2012	102					102	2
3			2017	2017	63,902					63,902	3
4											4
5											5
	Improvement Type										
6	Install 3 Outdoor Patios			2021	13,015	163	15	163		163	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)				\$ 10,714,309	\$ 305,250		\$ 305,250		\$ 3,134,820	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	\$ 606,615	\$ 1,446	\$ 183	(1,263)		\$ 603,133	18
19	Vehicles	85,423					85,423	19
20	TOTAL (lines 18 and 19)	\$ 692,038	\$ 1,446	\$ 183	(1,263)		\$ 688,556	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	N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Knollwood St Clair Ret Comm

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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			/ /	\$ N/A			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 \$ N/A

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	\$ 8,995,836	12/1/49	0.0360	\$ 262,970	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	IHDA		X	BUILDING	12/1/09	1,656,251	1,656,251	12/3/51			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 11,994,251	\$ 10,652,087			\$ 262,970	7
	B. Non-Facility Related										
8					/ /		Misc Interest Exp	/ /		474	8
9					/ /		Offset Int Inc	/ /		(3,463)	9
10	TOTALS (lines 7, 8 and 9)					\$ 11,994,251	\$ 10,652,087			\$ 259,981	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 12/31/21

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 558,804	\$ 558,804	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	1,086,951	1,086,951	3
4	Supply Inventory (priced <u>Cost</u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,757	82,757	6
7	Other Prepaid Expenses	9,586	9,586	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Ins & RE Escrow</u>	42,951	42,951	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,781,049	\$ 1,781,049	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	13,015	13,015	15
16	Equipment, at Historical Cost	692,038	692,038	16
17	Accumulated Depreciation (book methods)	(3,883,739) #	(3,823,376)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	823,365	823,365	21
22	Other Long-Term Assets (specify): <u>Intang Co</u>	191,052	191,052	22
23	Other(specify): <u>Deferred Fin Charges</u>	459,036	459,036	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,296,061	\$ 9,356,424	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,077,110	\$ 11,137,473	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 170,344	\$ 170,344	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,659	45,659	30
31	Accrued Taxes Payable	68,160	68,160	31
32	Accrued Interest Payable	27,614	27,614	32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Capital Lease Payable</u>	2,949	2,949	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 314,726	\$ 314,726	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,656,251	1,656,251	38
39	Mortgage Payable	8,995,836	8,995,836	39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	<u>Deferred Revenue</u>	59,965	59,965	42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 10,712,052	\$ 10,712,052	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,026,778	\$ 11,026,778	45
46	TOTAL EQUITY	\$ 50,332	\$ 110,695	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 11,077,110	\$ 11,137,473	47

*(See instructions.)

Facility Name: Knollwood St Clair Ret Comm

Report Period Beginning: 1/1/21

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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	\$ 3,320,380	1
2	Discounts and Allowances	(2,645)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,317,735	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	248,465	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	49	8
9	Non-Resident Meals	6,861	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 255,375	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,463	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,463	14
	D. Other Revenue (specify):		
15	Miscellaneous Income	45	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 45	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,576,618	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	959,124	19
20	Health Care/ Personal Care	510,786	20
21	General Administration	1,222,220	21
	B. Capital Expense		
22	Ownership	685,180	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)	\$ 3,377,310	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 199,308	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 199,308	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,884,277	32
33	Private Pay - Net Inpatient Revenue	247,002	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Food Stamps</u>	186,456	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 3,317,735	37