

FOR BHF USE							

LL2

Supportive Living Facility

2010

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2010)

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: 1000006

Facility Name: St. Francis Woods

Address: 3507 North Molleck Peoria 61604

Number City Zip Code

County: Peoria

Telephone Number: (309) 388-0093 Fax # 309 387-3550

0

Federal Employer ID Number:

Date Current Owners were Certified: 05-2004

Type of Ownership:

☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	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: Nancy Lee Telephone Number: (785) 989-2300

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 1-1-10 to 12-31-10 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)	3/22/2010
	(Type or Print Name)	Nancy R Lee
	(Title)	Agent/Owner
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 St. Francis Woods

Report Period Beginning: 1-1-10 Ending: 12-31-10

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	92	Single Unit Apartment	92	33,580	1
2		Double Unit Apartment			2
3		Other			3
4	92	TOTALS	92	33,580	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	27,360	2,660		30,020	5
6	Double Unit					6
7	Other					7
8	TOTALS	27,360	2,660		30,020	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.40%

D. Indicate the number of paid bed-hold days the SLF had during this year 111 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 301 (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: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle?
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.

Facility Name: St. Francis Woods

Report Period Beginning:

1-1-10

Ending:

12-31-10

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	114,243	202,152	612	317,007		317,007	1
2	Housekeeping, Laundry and Maintenance	76,292	9,816	9,586	95,694		95,694	2
3	Heat and Other Utilities			103,685	103,685		103,685	3
4	Other (specify): Trash Expense			6,488	6,488		6,488	4
5	TOTAL General Services	190,535	211,968	120,371	522,874		522,874	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	380,882	3,421		384,303		384,303	6
7	Activities and Social Services	22,848	3,616		26,464		26,464	7
8	Other (specify): Resident Transportation			2,528	2,528		2,528	8
9	TOTAL Health Care and Programs	403,730	7,037	2,528	413,295		413,295	9
	C. General Administration							
10	Administrative and Clerical	94,197	20,972	14,539	129,708		129,708	10
11	Marketing Materials, Promotions and Advertising	60,000	9,363		69,363		69,363	11
12	Employee Benefits and Payroll Taxes		151,470	26,496	177,966		177,966	12
13	Insurance-Property, Liability and Malpractice		51,975		51,975		51,975	13
14	Other (specify): Management Fees			91,509	91,509		91,509	14
15	TOTAL General Administration	154,197	233,780	132,544	520,521		520,521	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	748,462	452,785	255,443	1,456,690		1,456,690	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			162,317	162,317		162,317	17
18	Interest			334,861	334,861		334,861	18
19	Real Estate Taxes			100,670	100,670		100,670	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):Emergency Call System			5,216	5,216		5,216	22
23	TOTAL Ownership			603,064	603,064		603,064	23
24	GRAND TOTAL (Sum of lines 16 and 23)	748,462	452,785	858,507	2,059,754		2,059,754	24

equipment maint
contract services

Audit \$6880, 2 yr

Payroll Service F

Facility Name: St. Francis Woods

Report Period Beginning 1-1-10 Ending: 12-31-10

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 23.00	1
2	Licensed Practical Nurses	2	20.00	2
3	Certified Nurse Assistants	11	9.50	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	13.75	6
7	Cook Helpers/Assistants	4	8.50	7
8	Dishwashers			8
9	Maintenance Workers	1	13.75	9
10	Housekeepers	2	9.50	10
11	Laundry			11
12	Managers	1	29.00	12
13	Other Administrative	1	12.50	13
14	Clerical			14
15	Marketing	1	25.00	15
16	Other			16
17	Total (lines 1 thru 16)	26	\$ 175.50	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
N/A		

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	Robert Schleicher Managing Member	53%	35	\$ 156,000	1
2	Steven Schleicher Member	34%			2
3	Nancy Lee Member / Agent	13%	20	36,000	3
4					4
5					5
Total				\$ 192000	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1	Bionic Real Estate Services, LLC	\$ 91,509	1
2			2
Total		\$ 91,509	3

Facility Name: St. Francis Woods

Report Period Beginning:

1-1-10

Ending:

12-31-10

VIII. OWNERSHIP COSTS

A. Purchase price of land 760,000 Year land was acquired 2003

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	68		2003	1979	\$ 2,827,265	\$ 120,114	28	\$	(120,114)	\$ 846,032	1
2	24		2005	2005	1,300,000	42,203	28		(42,203)	297,717	2
3											3
4											4
5											5
6	Improvement Type										
6	Emergency Call System			2006	42,500	6,071	7		(6,071)	30,355	6
7	HVAC			2007	6,631	947	7		(947)	3,788	7
8	HVAC			2008	12,577	1,796	7		(1,796)	5,388	8
9	Dining Room Chairs			2009	10,454	1,463	7		(1,463)	2,926	9
10	ADA Restrooms			2010	16,320	2,331	7		(2,331)	2,331	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,215,747	\$ 174,925		\$	(174,925)	\$ 1,188,537	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	\$ 6,400	\$ 914	\$	(914)	7	\$ 3,656	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 6,400	\$ 914	\$	(914)		\$ 3,656	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: St. Francis Woods

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IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Not Applicable

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	Bank of America		X	Mortgage	5/28/04	\$ 5,043,823	\$ 4,964,132	/ /	variable	\$ 316,208	1
2	Bank of America		X	Mortgage 2nd	11/10/10	700,000		/ /			2
3					/ /			/ /			3
	Working Capital										
4	Bank of America		X	Line of Credit	5/28/04	150,000		/ /	variable	1,816	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,893,823	\$ 4,964,132			\$ 318,024	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,893,823	\$ 4,964,132			\$ 318,024	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: St. Francis Woods

Report Period Beginning: 1-1-10

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 193,833	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	31,722		3
4	Supply Inventory (priced at)	17,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,793		6
7	Other Prepaid Expenses	45,951		7
8	Accounts Receivable (owners or related parties)	237,896		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 530,695	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	760,000		13
14	Buildings, at Historical Cost	4,396,172		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	349,764		16
17	Accumulated Depreciation (book methods)	(1,143,287)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,896		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	544,090		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,934,635	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,465,330	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,011	\$	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	16,215		31
32	Accrued Interest Payable			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)	\$ 51,226	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	4,979,132		38
39	Mortgage Payable			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)	\$ 4,979,132	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,030,358	\$	45
46	TOTAL EQUITY	\$ 434,972	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,465,330	\$	47

*(See instructions.)

Facility Name: St. Francis Woods

Report Period Beginning: 1-1-10

Ending:

12-31-10

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

		1	
	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,847,508	1
2	Discounts and Allowances	(444,072)	2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 2,403,436	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		8
9	Non-Resident Meals		9
10	Laundry		10
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15	Food Stamps	64,960	15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$ 64,960	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 2,468,396	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	522,876	19
20	Health Care/ Personal Care	389,520	20
21	General Administration	346,076	21
	B. Capital Expense		
22	Ownership		22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26	Taxes and Insurance	304,117	26
27	Interest and Closing Costs	334,861	27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 1,897,450	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ 570,946	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ 570,946	31