

		FOR BHF USE			

LL2

**Supportive Living Facility**  
**2015**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE & FAMILY SERVICES**  
**COST REPORT FOR**  
**SUPPORTIVE LIVING FACILITIES**  
**(FISCAL YEAR 2015)**

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 ) 688-0093 **Fax #** 309 687-3550

**Federal Employer ID Number:** \_\_\_\_\_

**Date Current Owners were Certified:** 2004

**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:** Nancy Lee-McQuillan **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 1-1-2015 to 12-31-2015  
 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) Nancy R Lee-McQuillan

(Title) Agent

**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 WoodsReport Period Beginning: 1-1-2015 Ending: 12-31-2015

## III. STATISTICAL DATA

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

Date of change in certified units       /      /      

	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	20,714	6,905		27,619	5
6	Double Unit					6
7	Other					7
8	TOTALS	20,714	6,905		27,619	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified  
bed days on line 4, column 4.) 82.25%D. Indicate the number of paid bed-hold days the SLF had during this year  
204 Also, indicate the number of unpaid bed-hold days the SLF  
had during this year. 367 (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

ACCURAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐I. Is your fiscal year identical to your tax year? ☒ YES ☐ NOTax Year: Jan-Dec Fiscal Year: Jan-Dec

\* 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. \_\_\_\_\_

## STATE OF ILLINOIS

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Facility Name: St Francis Woods

Report Period Beginning:

1-1-2015

Ending:

12-31-2015

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments 5	Adjusted Total 6	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	<b>A. General Services</b>							
1	Dietary and Food Purchase	122,903	188,005		310,908		310,908	1
2	Housekeeping, Laundry and Maintenance	48,658	71,545	24,580	144,783		144,783	2
3	Heat and Other Utilities			105,473	105,473	(18,667)	86,806	3
4	Other (specify):			15,232	15,232		15,232	4
5	<b>TOTAL General Services</b>	171,561	259,550	145,285	576,396	(18,667)	557,729	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	394,398	10,655		405,053		405,053	6
7	Activities and Social Services	22,338	11,163	4,733	38,234		38,234	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	416,736	21,818	4,733	443,287		443,287	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	96,281	18,724	105,115	220,120		220,120	10
11	Marketing Materials, Promotions and Advertising	34,063	21,095	20,479	75,637		75,637	11
12	Employee Benefits and Payroll Taxes			188,623	188,623		188,623	12
13	Insurance-Property, Liability and Malpractice			52,668	52,668		52,668	13
14	Other (specify):			25,887	25,887		25,887	14
15	<b>TOTAL General Administration</b>	130,344	39,819	392,772	562,935		562,935	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	718,641	321,187	542,790	1,582,618	(18,667)	1,563,951	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			162,317	162,317		162,317	17
18	Interest			189,619	189,619		189,619	18
19	Real Estate Taxes			144,897	144,897	(36,083)	108,814	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			496,833	496,833	(36,083)	460,750	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	718,641	321,187	1,039,623	2,079,451	(54,750)	2,024,701	24

Contract Mai  
Resident Cat  
1740 - Dietar

Resident Tra

92,296 - Mgt  
2192 - Refer  
4466 - Traini

Payroll Servi

Income Tax

Facility Name: St Francis Woods

Report Period Beginning 1-1-2015

Ending:

12-31-2015

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 25.00	1
2	Licensed Practical Nurses	1	21.75	2
3	Certified Nurse Assistants	12	10.25	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	15.00	6
7	Cook Helpers/Assistants	4	10.00	7
8	Dishwashers			8
9	Maintenance Workers	1	15.00	9
10	Housekeepers	2	12.51	10
11	Laundry			11
12	Managers	1	28.84	12
13	Other Administrative	2	13.50	13
14	Clerical			14
15	Marketing	1	17.00	15
16	Other			16
17	Total (lines 1 thru 16)	27	\$	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
none			

**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	Robert Schleicher	82%	5	\$	1
2	Nancy Lee-McQuillan	18%	5		2
3					3
4					4
5					5
Total				\$	6

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

1	nLee Management and Consulting, LL	\$ 92,295	1
2			2
Total		\$ 92,295	3

Facility Name: St Francis Woods

Report Period Beginning:

1-1-2015

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## 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	\$	28	\$ 100,973	\$ 100,973	\$ 1,161,190	1
2	24		2005	2005	1,300,000		28	46,428	46,428	441,066	2
3											3
4											4
5											5
	Improvement Type										
6	Dining Room Chairs			2009	10,454		7	1,493	1,493	9,704	6
7	ADA Restrooms			2010	16,320		7	2,331	2,331	12,820	7
8	Emergency Call System			2011	42,500		7	6,071	6,071	30,355	8
9	Sprinkler System			2011	200,000		7	28,571	28,571	128,569	9
10	HVAC			2013	10,108		7	1,444	1,444	3,610	10
11	Hot Water Heater			2013	9,887		7	1,412	1,412	3,530	11
12	New Flooring Common Area			2014	10,300		7	1,471	1,471	2,206	12
13	Nurses Station			2014	8,380		7	698	698	1,047	13
14	HVAC			2015	13,640		7	974	974	974	14
15											
16											
17	TOTAL (lines 1 thru 16)				\$ 4,448,854	\$		\$ 191,866	\$ 191,866	\$ 1,795,071	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	\$ 16,151	\$	\$ 2,058	2,058	7	\$ 10,752	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 16,151	\$	\$ 2,058	2,058		\$ 10,752	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	none	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: St Francis Woods

Report Period Beginning: 1-1-2015

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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☐ NO9. 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	Midland States Bank		X	Mortgage	3/31/13	\$ 5,000,000	\$ 4,471,331	3/31/18	0.0470	\$ 176,458	1		
2	Nancy Lee-McQuillan	X		Member Buy Out	12/31/11	100,000	57,822	12/31/15	0.0600	2,754	2		
3					/ /			/ /			3		
	Working Capital												
4	Midland States Bank		X	Line of Credit	/ /		231,041	3/31/16	0.0500	10,407	4		
5					/ /			/ /			5		
6					/ /			/ /			6		
7	TOTAL Facility Related					\$ 5,100,000	\$ 4,760,194			\$ 189,619	7		
	B. Non-Facility Related												
8					/ /			/ /			8		
9					/ /			/ /			9		
10	TOTALS (lines 7, 8 and 9)					\$ 5,100,000	\$ 4,760,194			\$ 189,619	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.

## STATE OF ILLINOIS

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Facility Name: St Francis Woods

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2015

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,267	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	348,002		3
4	Supply Inventory (priced at )	15,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,398		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 387,667	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	632,047		11
12	Long-Term Investments			12
13	Land	760,000		13
14	Buildings, at Historical Cost	4,442,667		14
15	Leasehold Improvements, at Historical Cost	115,145		15
16	Equipment, at Historical Cost	566,442		16
17	Accumulated Depreciation (book methods)	(1,860,732)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	51,692		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 4,707,261	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,094,928	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 280,283	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	336,404		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	6,910		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 36)	\$ 623,597	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,471,331		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities</b> (sum of lines 38 thru 43)	\$ 4,471,331	\$	44
45	<b>TOTAL LIABILITIES</b> (sum of lines 37 and 44)	\$ 5,094,928	\$	45
46	<b>TOTAL EQUITY</b>	\$	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 45 and 46)	\$ 5,094,928	\$	47

\*(See instructions.)

Facility Name: St Francis Woods

Report Period Beginning: 1-1-2015

Ending:

12-31-2015

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

1			
	Revenue	Amount	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 2,928,062	1
2	Discounts and Allowances	(556,274)	2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 2,371,788	3
	<b>B. Other Operating Revenue</b>		
4	Special Services	58,101	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	4,572	7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 62,673	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$	14
	<b>D. Other Revenue (specify):</b>		
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 2,434,461	18

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
19	General Services	557,729	19
20	Health Care/ Personal Care	443,287	20
21	General Administration	562,935	21
	<b>B. Capital Expense</b>		
22	Ownership	460,750	22
	<b>C. Other Expenses</b>		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 2,024,701	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 409,760	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 409,760	31



## Cost Center Expenses

A.2	Other	Contract Maintenance
A.3	Adjustment	Resident Cable
A.4	Other	\$1750=Dietary Consultant, \$13,492=Trash Removal
B.7	Other	Resident Transportation
C.10	Other	\$92,296=Management Fee, \$5449=Telephone, \$4324=Memberships, \$3046=Software Lease
C.11	Other	\$2192=Referral Fees, \$18,287=Newspaper and radio advertising
C.12	Other	\$4466=Training, \$8604=Mileage, \$175,553=Payroll Taxes and Benefits
C.14	Other	Payroll Service Fees
D.19	Adjustment	Income Tax