

		FOR BHF USE					

LL2

Supportive Living Facility

**2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2014)**

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:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 1-1-2014 to 12-31-2014 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) <u>Nancy R Lee-McQuillan</u>	
	(Title) <u>Agent</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (<u> </u>) _____	Fax # (<u> </u>) _____
	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: 1-1-2014 Ending: 12-31-2014

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 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	24,008	6,382		30,390	5
6	Double Unit					6
7	Other					7
8	TOTALS	24,008	6,382		30,390	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 90.50%

D. Indicate the number of paid bed-hold days the SLF had during this year 282 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 421 **(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: 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

Facility Name: St Francis Woods

Report Period Beginning:

1-1-2014

Ending: 12-31-2014

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			
A. General Services								
1	Dietary and Food Purchase	108,175	203,010		311,185		311,185	1
2	Housekeeping, Laundry and Maintenance	58,497	42,339		100,836		100,836	2
3	Heat and Other Utilities			102,354	102,354	(18,014)	84,340	3
4	Other (specify): Trash Exp. + Dietician			12,823	12,823		12,823	4
5	TOTAL General Services	166,672	245,349	115,177	527,198	(18,014)	509,184	5
B. Health Care and Programs								
6	Health Care/ Personal Care	417,982	10,561	6,667	435,210		435,210	6
7	Activities and Social Services	22,684	8,844	4,318	35,846		35,846	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	440,666	19,405	10,985	471,056		471,056	9
C. General Administration								
10	Administrative and Clerical	91,687	16,574	104,853	213,114	(1,053)	212,061	10
11	Marketing Materials, Promotions and Advertising	20,472	10,104	34,883	65,459		65,459	11
12	Employee Benefits and Payroll Taxes			193,263	193,263		193,263	12
13	Insurance-Property, Liability and Malpractice			51,133	51,133		51,133	13
14	Other (specify):			23,424	23,424		23,424	14
15	TOTAL General Administration	112,159	26,678	407,556	546,393	(1,053)	545,340	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	719,497	291,432	533,718	1,544,647	(19,067)	1,525,580	16
Capital Expenses								
D. Ownership								
17	Depreciation			162,317	162,317		162,317	17
18	Interest			225,416	225,416		225,416	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):			8,017	8,017		8,017	22

Res Cable
1681 - Dietar

Em Call Syst
Res Transpor

95,600-Mgt l
TV and Radi
5460-training

Payroll Servi

Other Insura

23	TOTAL Ownership			496,420	496,420		496,420	23
24	GRAND TOTAL (Sum of lines 16 and 23)	719,497	291,432	1,030,138	2,041,067	(19,067)	2,022,000	24

ry Consultant, 11,142 - Trash Expense

tem
rtation

Fee, 2849-Sotware, 6404-Telephone, -1053-Bank Fees

o
3, 3050- Mileage

ice

nce

Facility Name: St Francis Woods

Report Period Beginning 1-1-2014

Ending:

12-31-2014

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 28.85	1
2	Licensed Practical Nurses	1	20.00	2
3	Certified Nurse Assistants	13	10.45	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	13.50	6
7	Cook Helpers/Assistants	3	10.25	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	1	10.00	10
11	Laundry			11
12	Managers	1	29.80	12
13	Other Administrative	1	13.75	13
14	Clerical			14
15	Marketing	1	16.00	15
16	Other			16
17	Total (lines 1 thru 16)	25	\$	17

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, LLC	\$ 95,600	1
2			2
		Total	3

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).

Facility Name: St Francis Woods

Report Period Beginning:

1-1-2014

Ending:

12-31-2014

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	\$ 97,491 #	\$ 97,491	\$ 1,121,146	1
2	24		2005	2005	1,300,000		28	44,827 #	44,827	425,856	2
3											3
4											4
5											5
Improvement Type											
6											6
7		HVAC		2008	12,577		7	2,025	2,025	12,577	7
8		Dining Room Chairs		2009	10,454		7	1,306	1,306	8,464	8
9		ADA Restrooms		2010	16,320		7	2,040	2,040	11,083	9
10		Emergency Call System		2011	42,500		7	5,312	5,312	19,730	10
11		Sprinkler System		2011	200,000		7	25,000	25,000	92,865	11
12		HVAC		2013	10,108		7	631	631	1,262	12
13		HotWater Heater		2013	9,887		7	618	618	1,236	13
14		New Flooring Common Area		2014	10,300		7	735	735	735	14
15		Nurses Station		2014	8,380		7	598	598	598	15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,447,791	\$		\$ 180,583	\$ 180,583	\$ 1,695,552	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	\$ 8,694	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 16,151	\$	\$ 2,058	2,058		\$ 8,694	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: 1-1-2014

Ending: 2-31-2014

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	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
							Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Midland States Bank		x	Mortgage	3/31/13	\$ 5,000,000	\$ 4,682,085	3/31/18	0.0470	\$ 214,350	1
2		Nancy Lee-McQuillan	x		Member Buy-out	12/31/11	100,000	67,727	12/31/15	0.0600	2,001	2
3						/ /			/ /			3
		Working Capital										
4		Midland States Bank		x	Line of Credit	/ /		206,120	3/31/15	0.0500	9,065	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 5,100,000	\$ 4,955,932			\$ 225,416	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 5,100,000	\$ 4,955,932			\$ 225,416	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: 1-1-2014

Ending:

12-31-2014

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2014

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 25,273	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	498,654		3
4	Supply Inventory (priced : <u>current value</u>)	15,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,624		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,166		8
9	Other(specify): <u>Utility Deposit</u>	6,102		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 556,819	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	632,047		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	51,141		15
16	Equipment, at Historical Cost	566,442		16
17	Accumulated Depreciation (book methods)	(1,704,246)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,896		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,729,452	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,286,271	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,182	\$	26
27	Officer's Accounts Payable	37,944		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	2,213		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)	\$ 330,339	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	273,847		38
39	Mortgage Payable	4,682,085		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)	\$ 4,955,932	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,286,271	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,286,271	\$	47

*(See instructions.)

Facility Name: St Francis Woods

Report Period Beginning: 1-1-2014

Ending:

12-31-2014

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	\$ 2,833,715	1
2	Discounts and Allowances	(285,660)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,548,055	3
B. Other Operating Revenue			
4	Special Services	54,961	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	888	7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 55,849	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	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)	\$ 2,603,904	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	509,184	19
20	Health Care/ Personal Care	471,056	20
21	General Administration	545,340	21
B. Capital Expense			
22	Ownership	496,420	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)	\$ 2,022,000	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 581,904	29
30	Income Taxes	\$ 8,017	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 573,887	31

IV. Cost Center Expenses

- A.3 (\$18,014) Resident Cable Expense
- A.4 \$1681 = Dietary Consultant, \$11,142 = Trash Expense
- B.6 \$6667 = Emergency Call System
- B.7 \$4318 = Resident Transportation
- C.10 \$95600 = Mgt Fee, \$2849=Software Rental, \$6404=Telephone, (\$1053)=Bank Fees
- C.11 TV and Radio Ads
- C.12 \$5460=Training, \$3050=Mileage
- C.14 \$23,424=Payroll Service
- D.22 \$8017=Other Insurance

