

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2006  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2006)**

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.

<p><b>I.</b></p> <p>Facility Name: <u>St. Francis Woods</u></p> <p>Address: <u>3507 N. Molleck</u> <u>Peoria</u> <u>61604</u>  <small>Number City Zip Code</small></p> <p>County: <u>Peoria</u></p> <p>Telephone Number: ( <u>309</u> ) <u>688-0093</u> Fax # <u>309 687-3550</u></p> <p>Federal Employer ID Number: <u>90-0062914</u></p> <p>Date Current Owners were Certified: <u>May-04</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:  Name: <u>Nancy Lee</u> Telephone Number: <u>(816) 554-8998</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-1-06</u> to <u>12-31-06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td align="right">4/19/2007 (Date)</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Nancy R Lee</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Agent/Owner</u></td> <td></td> </tr> <tr> <td></td> <td>(Signed) _____</td> <td align="right">(Date)</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) ( _____ )</td> <td>Fax # ( _____ )</td> </tr> <tr> <td align="center" colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	4/19/2007 (Date)		(Type or Print Name) <u>Nancy R Lee</u>			(Title) <u>Agent/Owner</u>			(Signed) _____	(Date)	Paid Preparer	(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	
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Facility Name St. Francis Woods

Report Period Beginning: 1-1-06 Ending: 12-31-06

**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	28,828	1
2		Double Unit Apartment			2
3		Other			3
4	92	TOTALS	92	28,828	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	17,642	6,861		24,503	5
6	Double Unit					6
7	Other					7
8	TOTALS	17,642	6,861		24,503	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 85.00%

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

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**H. ACCOUNTING BASIS**

ACCURAL  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:

1-1-06

Ending:

12-31-06

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	113,586	181,239	808	295,633		295,633	1
2	Housekeeping, Laundry and Maintenance	84,195	30,149	4,329	118,673		118,673	2
3	Heat and Other Utilities			85,401	85,401	(11,632)	73,769	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	197,781	211,388	90,538	499,707	(11,632)	488,075	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	292,290	1,482		293,772		293,772	6
7	Activities and Social Services	42,623	6,017	2,232	50,872		50,872	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	334,913	7,499	2,232	344,644		344,644	9
<b>C. General Administration</b>								
10	Administrative and Clerical	113,137	19,851	99,472	232,460		232,460	10
11	Marketing Materials, Promotions and Advertising		1,925		1,925		1,925	11
12	Employee Benefits and Payroll Taxes	154,173			154,173		154,173	12
13	Insurance-Property, Liability and Malpractice	29,411			29,411		29,411	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	296,721	21,776	99,472	417,969		417,969	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	829,415	240,663	192,242	1,262,320	(11,632)	1,250,688	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			105,289	105,289		105,289	17
18	Interest							18
19	Real Estate Taxes			69,996	69,996		69,996	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			175,285	175,285		175,285	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	829,415	240,663	367,527	1,437,605	(11,632)	1,425,973	24

Cable Expen:

Facility Name: St. Francis Woods

Report Period Beginning 1-1-06 Ending: 12-31-06

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 21.25	1
2	Licensed Practical Nurses	2	18.00	2
3	Certified Nurse Assistants	8	10.00	3
4	Activity Director & Assistants	1	10.00	4
5	Social Service Workers			5
6	Head Cook	1	14.00	6
7	Cook Helpers/Assistants	3	10.00	7
8	Dishwashers			8
9	Maintenance Workers	1	12.00	9
10	Housekeepers	2	9.50	10
11	Laundry			11
12	Managers	1	27.88	12
13	Other Administrative	2	11.50	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>22</b>	<b>\$</b>	<b>17</b>

**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	40%		\$	1
2	Perry Kessler	31%			2
3	Steven Schleicher	18%			3
4	Nancy Lee	11%			4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

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

	Amount of Fee	
1	BIONIC Real Estate Services, LLC	\$ 84,827 1
2		
<b>Total</b>		<b>\$ 84,827 3</b>

**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 <u>1</u>	City <u>2</u>
None	

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
None		

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:

1-1-06

Ending:

12-31-06

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	\$ 151,900	28	\$	\$ (151,900)	\$ 452,768	1
2	24		2005	2005	1,300,000	47,272	28		(47,272)	70,908	2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Emergency Call System			42,500	6,271	7		(6,271)	6,271	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)				\$ 4,169,765	\$ 205,443		\$	\$ (205,443)	\$ 529,947	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	\$ 192,659	\$	\$ 27,542	27,542	7	\$ 105,824	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 192,659	\$	\$ 27,542	27,542		\$ 105,824	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		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: St. Francis Woods

Report Period Beginning: 1-1-06

Ending: 12-31-06

**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	<b>TOTAL</b>				\$			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			
	<b>A. Directly Facility Related Long-Term</b>									
1	Bank of America		X	Mortgage	05/ 28/04	\$ 5,043,823	\$ 4,905,197	5/1/14	variable	\$ 249,904
2					/ /			/ /		
3					/ /			/ /		
	<b>Working Capital</b>									
4	Bank of America		X	Line of Credit	5/28/04	150,000	126,049	5/1/07	Variable	5,039
5					/ /			/ /		
6					/ /			/ /		
7	<b>TOTAL Facility Related</b>					\$ 5,193,823	\$ 5,031,246			\$ 254,943
	<b>B. Non-Facility Related</b>									
8	none				/ /			/ /		
9					/ /			/ /		
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 5,193,823	\$ 5,031,246			\$ 254,943

\* 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

Report Period Beginning: 1-1-06

Ending:

12-31-06

12-31-06

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-06

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 97,361	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	555,801		3
4	Supply Inventory (priced at )	5,640		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,295		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	24,000		8
9	Other(specify): <b>Development Costs</b>	146,980		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 856,077	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	760,000		13
14	Buildings, at Historical Cost	4,108,351		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	254,806		16
17	Accumulated Depreciation (book methods)	(335,861)		17
18	Deferred Charges	6,102		18
19	Organization & Pre-Operating Costs			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 (sum of lines 11 thru 23)</b>	\$ 4,793,398	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,649,475	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 141,587	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	149,517		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	19,109		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 (sum of lines 26 thru 36)</b>	\$ 310,213	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	5,153,322		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 (sum of lines 38 thru 43)</b>	\$ 5,153,322	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 5,463,535	\$	45
46	<b>TOTAL EQUITY</b>	\$ 185,940	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 5,649,475	\$	47

\*(See instructions.)

Facility Name: St. Francis Woods

Report Period Beginning: 1-1-06

Ending:

12-31-06

**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	\$ 2,201,925	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 2,201,925	3
<b>B. Other Operating Revenue</b>			
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
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$	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)	\$ 2,201,925	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	499,707	19
20	Health Care/ Personal Care	344,644	20
21	General Administration	417,969	21
<b>B. Capital Expense</b>			
22	Ownership	175,285	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)	\$ 1,437,605	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 764,320	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 764,320	31