

		FOR BHF USE			

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Supportive Living Facility

**2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2008)**

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>I.</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>816-749-4234</u> Email Address: _____</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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-1-08</u> to <u>12-31-08</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 style="width:100%"> <tr> <td style="width:50%; vertical-align: top;"> <p>Officer or Administrator of Provider</p> <p>Paid Preparer</p> </td> <td style="width:50%; vertical-align: top;"> <p>(Signed) _____ <small>(Date)</small> <u>4/23/2009</u></p> <p>(Type or Print Name) <u>Nancy R Lee</u></p> <p>(Title) <u>Agent/Owner</u></p> <p>(Signed) _____ <small>(Date)</small></p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (_____) Fax # (_____)</p> </td> </tr> </table> <p align="right">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</p>	<p>Officer or Administrator of Provider</p> <p>Paid Preparer</p>	<p>(Signed) _____ <small>(Date)</small> <u>4/23/2009</u></p> <p>(Type or Print Name) <u>Nancy R Lee</u></p> <p>(Title) <u>Agent/Owner</u></p> <p>(Signed) _____ <small>(Date)</small></p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (_____) Fax # (_____)</p>
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Facility Name: St. Francis Woods

Report Period Beginning:

1-1-08

Ending:

12-31-08

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	124,604	225,911		350,515		350,515	1
2	Housekeeping, Laundry and Maintenance	90,211	21,133		111,344		111,344	2
3	Heat and Other Utilities			105,687	105,687		105,687	3
4	Other (specify): Trash Service			5,759	5,759		5,759	4
5	TOTAL General Services	214,815	247,044	111,446	573,305		573,305	5
B. Health Care and Programs								
6	Health Care/ Personal Care	323,481	2,030		325,511		325,511	6
7	Activities and Social Services	17,444	7,346		24,790		24,790	7
8	Other (specify): Resident Transportation			2,047	2,047		2,047	8
9	TOTAL Health Care and Programs	340,925	9,376	2,047	352,348		352,348	9
C. General Administration								
10	Administrative and Clerical	102,888	17,200	8,983	129,071		129,071	10
11	Marketing Materials, Promotions and Advertising		6,819		6,819		6,819	11
12	Employee Benefits and Payroll Taxes	166,673		20,493	187,166		187,166	12
13	Insurance-Property, Liability and Malpractice	30,613		5,000	35,613		35,613	13
14	Other (specify): Management Fee			80,145	80,145		80,145	14
15	TOTAL General Administration	300,174	24,019	114,621	438,814		438,814	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	855,914	280,439	228,114	1,364,467		1,364,467	16
Capital Expenses								
D. Ownership								
17	Depreciation			161,540	161,540		161,540	17
18	Interest			335,265	335,265		335,265	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			12,550	12,550		12,550	22
23	TOTAL Ownership			610,025	610,025		610,025	23
24	GRAND TOTAL (Sum of lines 16 and 23)	855,914	280,439	838,139	1,974,492		1,974,492	24

Software and
Payroll Servi
Attorney Fee

Facility Name: St. Francis Woods

Report Period Beginning 1-1-08 Ending: 12-31-08

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 22.25	1
2	Licensed Practical Nurses	2	19.00	2
3	Certified Nurse Assistants	11	10.00	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	12.50	6
7	Cook Helpers/Assistants	4	10.25	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	2	10.00	10
11	Laundry			11
12	Managers	1	29.00	12
13	Other Administrative	2	13.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	26	\$	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	53%		\$	1
2	Steven Schleicher	34%			2
3	Nancy Lee	13%			3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Bionic Real Estate Services, LLC	\$ 80,145	1
2			2
Total		\$ 80,145	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 <u>1</u>	City <u>2</u>

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>

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).

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Report Period Beginning:

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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	\$ 111,462	28	\$	\$ (111,462)	\$ 543,709	1
2	24		2005	2005	1,300,000	50,078	28		(50,078)	244,276	2
3											3
4											4
5											5
Improvement Type											
6		Emergency Call System		2006	42,500	6,071	7		(6,071)	18,213	6
7		HVAC		2007	6,631	947	7		(947)	1,894	7
8		HVAC		2008	12,577	1,796	7		(1,796)	1,796	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,188,973	\$ 170,354		\$	\$ (170,354)	\$ 809,888	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	\$ 1,828	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 6,400	\$ 914	\$	(914)		\$ 1,828	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: 1-1-08

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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	\$ 4,701,747	5/1/14	variable	\$ 330,232
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	Bank of America		X	Line of Credit	5/28/04	150,000	94,517	5/1/14	variable	5,032
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 5,193,823	\$ 4,796,264			\$ 335,264
	B. Non-Facility Related									
8	None				/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 5,193,823	\$ 4,796,264			\$ 335,264

* 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

Facility Name: St. Francis Woods

Report Period Beginning: 1-1-08

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12-31-08

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-08

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 95,910	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	445,716		3
4	Supply Inventory (priced at)	3,215		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,562		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 561,403	\$	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	4,253,959		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	287,534		16
17	Accumulated Depreciation (book methods)	(787,985)		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,519,610	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,081,013	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 112,270	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	94,517		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	23,108		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)	\$ 229,895	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,851,118		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)	\$ 4,851,118	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,081,013	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,081,013	\$	47

*(See instructions.)

Facility Name: St. Francis Woods

Report Period Beginning: 1-1-08

Ending:

12-31-08

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	\$ 2,324,013	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,324,013	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
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	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)	\$ 2,324,013	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	573,305	19
20	Health Care/ Personal Care	352,348	20
21	General Administration	438,814	21
B. Capital Expense			
22	Ownership	610,025	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)	\$ 1,974,492	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 349,521	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 349,521	31