FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 Name: St. Francis Woods

Address: 3507 North Molleck (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309) 688-0093 **Fax #** 309 687-3550

Federal Employer ID Number: 90-0062914

Date Current Owners were Certified: 05/2004

Type of Ownership:

	VOLUNTARY, NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Nancy Lee **Telephone Number:** (816 749-4234
Email Address: nancy@bionicllc.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from _____ to _____ 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) 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: Ending:

III. STATISTICAL DATA

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

Date of change in certified units n/a

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	23,236	6,973		30,209	5
6	Double Unit					6
7	Other					7
8	TOTALS	23,236	6,973		30,209	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 89.96%

D. Indicate the number of paid bed-hold days the SLF had during this year 89 **Also, indicate the number of unpaid bed-hold days the SLF had during this year.** 436 **(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 [X]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [X]

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)
None

H. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [X] 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:** **Ending:**

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	122,049	191,151	2,694	315,894		315,894	1	equipment maint.
2	Housekeeping, Laundry and Maintenance	79,997	9,652	7,067	96,716		96,716	2	contract services
3	Heat and Other Utilities			101,411	101,411		101,411	3	
4	Other (specify): Trash Service			6,673	6,673		6,673	4	
5	**TOTAL General Services**	202,046	200,803	117,845	520,694		520,694	5	
	B. Health Care and Programs								
6	Health Care/ Personal Care	350,816	2,566		353,382		353,382	6	
7	Activities and Social Services	18,183	3,954		22,137		22,137	7	
8	Other (specify): Resident Transportation			4,735	4,735		4,735	8	
9	**TOTAL Health Care and Programs**	368,999	6,520	4,735	380,254		380,254	9	
	C. General Administration								
10	Administrative and Clerical	94,704	18,491	14,125	127,320		127,320	10	Audit=6880, AAI
11	Marketing Materials, Promotions and Advertising	14,038	4,846		18,884		18,884	11	software=3330
12	Employee Benefits and Payroll Taxes		177,591	23,791	201,382		201,382	12	Payroll service fe
13	Insurance-Property, Liability and Malpractice		32,404	18,263	50,667		50,667	13	
14	Other (specify): Management Fee			84,796	84,796		84,796	14	
15	**TOTAL General Administration**	108,742	233,332	140,975	483,049		483,049	15	
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	679,787	440,655	263,555	1,383,997		1,383,997	16	
	Capital Expenses								
	D. Ownership								
17	Depreciation			162,317	162,317		162,317	17	
18	Interest			373,618	373,618		373,618	18	
19	Real Estate Taxes			100,946	100,946		100,946	19	
20	Rent -- Facility and Grounds							20	
21	Rent -- Equipment							21	
22	Other (specify): Emergency Call System			14,437	14,437		14,437	22	
23	**TOTAL Ownership**			651,318	651,318		651,318	23	
24	**GRAND TOTAL (Sum of lines 16 and 23)**	679,787	440,655	914,873	2,035,315		2,035,315	24	

Facility Name: St. Francis Woods **Report Period Beginning** **Ending:**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	$ 22.50	1
2	Licensed Practical Nurses	2	20.00	2
3	Certified Nurse Assistants	11	9.50	3
4	Activity Director & Assistants	1	10.75	4
5	Social Service Workers			5
6	Head Cook	1	13.25	6
7	Cook Helpers/Assistants	4	9.50	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	2	9.50	10
11	Laundry			11
12	Managers	1	28.00	12
13	Other Administrative	1	12.00	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	**Total (lines 1 thru 16)**	25	$ 148.00	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 Managing Member	53%	30	$ 100,952	1
2	Steven Schleicher Member	34%		80,295	2
3	Nancy Lee Member / Agent	13%	20	33,851	3
4					4
5					5
			Total	$ 215098	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Bionic Real Estate Services, LLC	$ 84,796	1
2			2
	Total	$ 84,796	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	
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 [X]
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 [X]
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:** **Ending:**

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	$ 125,965	28	$	$ (125,965)	$ 655,389	1
2	24		2005	2005	1,300,000	50,078	28		(50,078)	294,451	2
3											3
4											4
5											5
	Improvement Type										
6	Emergency Call System			2006	42,500	6,071	7		(6,071)	24,284	6
7	HVAC			2007	6,631	947	7		(947)	2,836	7
8	HVAC			2008	12,577	1,796	7		(1,796)	3,582	8
9	Dining Room Chairs			2009	10,454	1,463	7		(1,463)	1,463	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 4,199,427	$ 186,320		$	$ (186,320)	$ 982,005	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	$ 2,742	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 6,400	$ 914	$	(914)		$ 2,742	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 Report Period Beginning: Ending:

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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 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 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	Bank of America		X	Mortgage	5/28/04	$ 5,043,823	$ 4,384,359	5/1/04	variable	$ 370,301	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	Bank of America		X	Line of Credit	5/28/04	150,000	104,517	5/1/14	variable	3,317	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 5,193,823	$ 4,488,876			$ 373,618	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 5,193,823	$ 4,488,876			$ 373,618	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:** **Ending:**

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** _____ **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,235	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	370,396		3
4	Supply Inventory (priced at)	15,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,761		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)**	$ 415,392	$	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	408,352		16
17	Accumulated Depreciation (book methods)	(950,302)		17
18	Deferred Charges			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)**	$ 4,614,222	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,029,614	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 69,070	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	175,042		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	18,615		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)**	$ 262,727	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,442,039		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)**	$ 4,442,039	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 4,704,766	$	45
46	**TOTAL EQUITY**	$ 324,848	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 5,029,614	$	47

***(See instructions.)**

Facility Name: St. Francis Woods **Report Period Beginning:** **Ending:**

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	$ 2,827,036	1
2	Discounts and Allowances	(417,519)	2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,409,517	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	**Food Stamps**	77,662	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 77,662	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 2,487,179	18

		2	
	Expenses	**Amount**	
	A. Operating Expenses		
19	General Services	520,694	19
20	Health Care/ Personal Care	380,254	20
21	General Administration	483,049	21
	B. Capital Expense		
22	Ownership	651,318	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)**	$ 2,035,315	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 451,864	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 451,864	31