

		FOR BHF USE					

LL2

Supportive Living Facility

**2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)**

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. Facility ID Number: <u>1000006</u></p> <p>Facility Name: <u>St Francis Woods</u></p> <p>Address: <u>3507 North 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: _____</p> <p>Date Current Owners were Certified: <u>2004</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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-McQuillan</u> Telephone Number: (<u>785</u>) <u>989-2300</u> Email Address: _____</p>	<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 _____		<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>1-1-2013</u> to <u>12-31-2013</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:20%; vertical-align: top;"> Officer or Administrator of Provider </td> <td> (Signed) _____ (Type or Print Name) <u>Nancy R Lee-McQuillan</u> (Title) <u>Agent</u> </td> </tr> <tr> <td style="vertical-align: top;"> Paid Preparer </td> <td> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (<u> </u>) _____ Fax # (<u> </u>) _____ </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>	Officer or Administrator of Provider	(Signed) _____ (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>) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name: St Francis Woods

Report Period Beginning:

1-1-2013

Ending: 12-31-2013

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	119,825	200,296		320,121		320,121	1
2	Housekeeping, Laundry and Maintenance	60,428	39,302		99,730		99,730	2
3	Heat and Other Utilities			97,895	97,895	(16,828)	81,067	3
4	Other (specify):			10,762	10,762		10,762	4
5	TOTAL General Services	180,253	239,598	108,657	528,508	(16,828)	511,680	5
B. Health Care and Programs								
6	Health Care/ Personal Care	412,099	7,191	17,676	436,966		436,966	6
7	Activities and Social Services	24,126	6,003	6,025	36,154		36,154	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	436,225	13,194	23,701	473,120		473,120	9
C. General Administration								
10	Administrative and Clerical	95,840	15,240	116,882	227,962	(1,450)	226,512	10
11	Marketing Materials, Promotions and Advertising	76,077	9,183	62,231	147,491		147,491	11
12	Employee Benefits and Payroll Taxes			195,284	195,284		195,284	12
13	Insurance-Property, Liability and Malpractice			33,295	33,295		33,295	13
14	Other (specify):			24,002	24,002		24,002	14
15	TOTAL General Administration	171,917	24,423	431,694	628,034	(1,450)	626,584	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	788,395	277,215	564,052	1,629,662	(18,278)	1,611,384	16
Capital Expenses								
D. Ownership								
17	Depreciation			179,625	179,625		179,625	17
18	Interest			219,021	219,021		219,021	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):			29,715	29,715		29,715	22
23	TOTAL Ownership			529,031	529,031		529,031	23
24	GRAND TOTAL (Sum of lines 16 and 23)	788,395	277,215	1,093,083	2,158,693	(18,278)	2,140,415	24

Cable / Resic
Trash Expen:Em Call Syst
Res TransporTelephone-5
TV ads, new:

Payroll servi

Other ins-10:

Facility Name: St Francis Woods

Report Period Beginning 1-1-2013

Ending:

12-31-2013

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	2	19.38	2
3	Certified Nurse Assistants	14	10.20	3
4	Activity Director & Assistants	1	11.00	4
5	Social Service Workers			5
6	Head Cook	1	14.50	6
7	Cook Helpers/Assistants	4	10.02	7
8	Dishwashers			8
9	Maintenance Workers	1	15.00	9
10	Housekeepers	1	10.00	10
11	Laundry			11
12	Managers	1	29.80	12
13	Other Administrative	1	13.25	13
14	Clerical			14
15	Marketing	1	28.84	15
16	Other			16
17	Total (lines 1 thru 16)	28	\$ 190.84	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%	30	\$ 60,000	1
2	Nancy Lee-McQuillan	18%	5		2
3					3
4					4
5					5
				Total	\$ 60000 6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	nLee Management and Consulting	\$ 110,897	1
2			2
		Total	\$ 110,897 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:

1-1-2013

Ending:

12-31-2013

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	\$ 1,023,655	1
2	24		2005	2005	1,300,000		28	44,827	44,827	381,029	2
3											3
4											4
5											5
Improvement Type											
6		HVAC		2007	6,631		7	828	828	6,510	6
7		HVAC		2008	12,577		7	1,572	1,572	10,552	7
8		Dining Room Chairs		2009	10,454		7	1,306	1,306	7,158	8
9		ADA Restrooms		2010	16,320		7	2,040	2,040	9,033	9
10		Emergency Call System		2011	42,500		7	5,312	5,312	14,418	10
11		Sprinkler System		2011	200,000		7	25,000	25,000	67,865	11
12		HVAC		2013	10,108		7	631	631	631	12
13		Hot Water Heater		2013	9,887		7	618	618	618	13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 4,435,742	\$		\$ 179,625	\$ 179,625	\$ 1,521,469	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	\$ 12,851	\$	\$ 1,587	1,587	7	\$ 6,636	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 12,851	\$	\$ 1,587	1,587		\$ 6,636	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: 1-1-2013

Ending: 2-31-2013

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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
A. Directly Facility Related												
Long-Term												
1		Midland States Bank		X	Mortgage	3/31/13	\$ 5,000,000	\$ 4,882,968	3/31/18	variable	\$ 211,592	1
2		Nancy Lee-McQuillan	X		Member Buy-out	12/31/11	100,000	82,006	12/31/14	0.0600	2,440	2
3						/ /			/ /			3
Working Capital												
4		Midland States Bank		X	Line of Credit	3/31/13		145,000	3/31/14	0.0425	4,407	4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 5,100,000	\$ 5,109,974			\$ 218,439	7
B. Non-Facility Related												
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 5,100,000	\$ 5,109,974			\$ 218,439	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: 1-1-2013

Ending:

12-31-2013

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2013

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,244	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	383,368		3
4	Supply Inventory (priced : <u>current value</u>)	15,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,201		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,166		8
9	Other(specify): <u>Utility Deposits</u>	6,102		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 428,081	\$	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)	(1,528,105)		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)	\$ 4,905,593	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,333,674	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 226,784	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	6,055		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)	\$ 232,839	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	227,006		38
39	Mortgage Payable	4,882,968		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)	\$ 5,109,974	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,342,813	\$	45
46	TOTAL EQUITY	\$ (9,139)	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,333,674	\$	47

*(See instructions.)

Facility Name: St Francis Woods

Report Period Beginning: 1-1-2013

Ending:

12-31-2013

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	\$ 2,742,046	1
2	Discounts and Allowances	(415,654)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,326,392	3
B. Other Operating Revenue			
4	Special Services	72,941	4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	2,050	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)	\$ 74,991	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)	\$ 2,401,383	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	511,680	19
20	Health Care/ Personal Care	473,120	20
21	General Administration	626,584	21
B. Capital Expense			
22	Ownership	529,031	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)	\$ 2,140,415	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 260,968	29
30	Income Taxes	\$ 20,378	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 240,590	31

