

		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>Saint Clare's Villa</u></p> <p>Address: <u>915 East 5th Street</u> <u>Alton</u> <u>62002</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>463-9000</u> Fax # (<u>618</u>) <u>463-0995</u></p> <p>Federal Employer ID Number: <u>37-1397289</u></p> <p>Date Current Owners were Certified: <u>4/8/02</u></p> <p>Type of Ownership:</p> <table border="0"> <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 checked="" 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 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>Terry Dooling, CPA</u> Telephone Number: <u>(618) 465-7717</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 checked="" 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 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 border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) <u>Mark F. Weber, FACHE</u></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>President & CEO Saint Anthony's Health System</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report Attached</u></td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>J. Terry Dooling, CPA</u> <u>Partner</u></td> </tr> <tr> <td colspan="2">(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p align="center">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) _____	(Date) _____	(Type or Print Name) <u>Mark F. Weber, FACHE</u>			(Title) <u>President & CEO Saint Anthony's Health System</u>		Paid Preparer	(Signed) <u>See Accountant's Compilation Report Attached</u>	(Date) _____	(Print Name and Title) <u>J. Terry Dooling, CPA</u> <u>Partner</u>		(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
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STATE OF ILLINOIS

Page 3

Facility Name: Saint Clare's Villa

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	107,569		167,084	274,653		274,653	1
2	Housekeeping, Laundry and Maintenance	59,207	5,323	151,001	215,531		215,531	2
3	Heat and Other Utilities			254,286	254,286		254,286	3
4	Other (specify): Security			48,845	48,845		48,845	4
5	TOTAL General Services	166,776	5,323	621,216	793,315		793,315	5
B. Health Care and Programs								
6	Health Care/ Personal Care	356,063	3,921		359,984		359,984	6
7	Activities and Social Services	25,182	3,220		28,402		28,402	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	381,245	7,141		388,386		388,386	9
C. General Administration								
10	Administrative and Clerical	121,624	7,070	168,657	297,351	(3,177)	294,174	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			240,780	240,780		240,780	12
13	Insurance-Property, Liability and Malpractice			30,591	30,591		30,591	13
14	Other (specify):							14
15	TOTAL General Administration	121,624	7,070	440,028	568,722	(3,177)	565,545	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	669,645	19,534	1,061,244	1,750,423	(3,177)	1,747,246	16
Capital Expenses								
D. Ownership								
17	Depreciation			346,392	346,392		346,392	17
18	Interest			25,923	25,923	(8)	25,915	18
19	Real Estate Taxes			19,187	19,187		19,187	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			694	694		694	21
22	Other (specify): Amortization			6,040	6,040		6,040	22
23	TOTAL Ownership			398,236	398,236	(8)	398,228	23
24	GRAND TOTAL (Sum of lines 16 and 23)	669,645	19,534	1,459,480	2,148,659	(3,185)	2,145,474	24

Facility Name: Saint Clare's Villa

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	1.71	\$ 29.24	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	9.72	12.43	3
4	Activity Director & Assistants	1.02	11.79	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	3.58	13.41	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	3.07	9.26	10
11	Laundry			11
12	Managers	1.00	29.99	12
13	Other Administrative	1.71	16.44	13
14	Clerical			14
15	Marketing			15
16	Other - Dining Room Assistant	0.55	7.77	16
17	Total (lines 1 thru 16)	22.36	\$ 14.40	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	None			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	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
Saint Anthony's Health Center		Alton, IL	

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
NDC Corp Equity Fd. IV		New York, NY		Limited Ptnr.	
Saint Anthony's, L.L.C.		Alton, IL		General Ptnr.	
NCC Housing & Economic Development Corp.		New York, NY		Project Oversight	

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: SainSt. Clare's Villa

Report Period Beginning:

1/1/08

Ending:

12/31/08

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

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	64			2002	\$ 9,619,761	\$ 344,228		\$ 344,228	\$	2,436,001	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Beauty Shop			2003	3,685	134		134		842	6
7	Vinyl Flooring			2006	3,910	142		142		290	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)				\$ 9,627,356	\$ 344,504		\$ 344,504	\$	2,437,133	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	\$ 198,629	\$ 1,887	\$ 1,250	(637)		\$ 199,386	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 198,629	\$ 1,887	\$ 1,250	(637)		\$ 199,386	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	Section N/A	\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Saint Clare's Villa

Report Period Beginning: 1/1/08

Ending: 12/31/08

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: N/A

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						
		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	IHDA Trust Fund		X	Building & Improvements	7/19/01	\$ 750,000	\$ 651,643	8/1/41	0.0100	\$ 6,604	1					
2	Madison County C.D.		X	Building & Improvements	Not Dated	300,000	300,000	10/1/41	0.0582	19,301	2					
3					/ /			/ /			3					
Working Capital																
4					/ /			/ /			4					
5					/ /			/ /			5					
6					/ /			/ /			6					
7	TOTAL Facility Related					\$ 1,050,000	\$ 951,643			\$ 25,905	7					
B. Non-Facility Related																
8					/ /			/ /			8					
9					/ /			/ /			9					
10	TOTALS (lines 7, 8 and 9)					\$ 1,050,000	\$ 951,643			\$ 25,905	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.

Interest of Security Deposits 18
Sched. IV, Line 18 25,923

STATE OF ILLINOIS

Page 7

Facility Name: Saint Clare's Villa

Report Period Beginning: 1/1/08

Ending:

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	\$ 19,174	\$ 1
2	Cash-Patient Deposits	3,460	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	250,075	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance		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)	\$ 272,709	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost	9,473,867	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	352,118	16
17	Accumulated Depreciation (book methods)	(2,633,853)	17
18	Deferred Charges	23,945	18
19	Organization & Pre-Operating Costs		19
	Accumulated Amortization -		
20	Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify): Oper. & Repl. Reserves	287,245	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,503,322	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,776,031	\$ 25

*(See instructions.)

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 5,731	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	3,426	28
29	Short-Term Notes Payable	16,315	29
30	Accrued Salaries Payable		30
31	Accrued Taxes Payable	22,312	31
32	Accrued Interest Payable	84,256	32
33	Deferred Compensation		33
34	Federal and State Income Taxes		34
	Other Current Liabilities(specify):		
35	Due to Affiliates	572,320	35
36	Rents Received in Advance	5,514	36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 709,874	\$ 37
D. Long-Term Liabilities			
38	Long-Term Notes Payable		38
39	Mortgage Payable	935,328	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)	\$ 935,328	\$ 44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,645,202	\$ 45
46	TOTAL EQUITY	\$ 6,130,829	\$ 46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 7,776,031	\$ 47

Facility Name: Saint Clare's Villa

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	\$ 1,764,642	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 1,764,642	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$	11
C. Non-Operating Revenue			
12	Contributions	323	12
13	Interest and Other Investment Income	18,860	13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 19,183	14
D. Other Revenue (specify):			
15	Application Fees	250	15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$ 250	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 1,784,075	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	793,315	19
20	Health Care/ Personal Care	388,386	20
21	General Administration	568,722	21
B. Capital Expense			
22	Ownership	398,236	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,148,659	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (364,584)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (364,584)	31

Saint Clare's Villa
 SLF Cost Report - Adjustments
 12/31/08

Attachment 1

<u>Adj #</u>	<u>Cost Center</u>	<u>Line</u>	<u>Col</u>	<u>Amount</u>
1	Depreciation	17	5	629
	To add depreciation expense for minor equipment expensed in prior year. VIII - 3			
2	Administrative and Clerical	10	5	(1,661)
	To eliminate sales tax expense Grouper			
3	Depreciation Expense	17	5	(637)
	To adjust for non-straight line depreciation VIII - 2			
4	Administrative and Clerical	10	3	(1,516)
	To Eliminate Bad debt Expense			
				<u><u>(3,185)</u></u>

Saint Clare's Villa
SLF Cost Report
Related Party Disclosure
December 31, 2008

Attachment 2

Saint Clare's Villa (SCV) is owned 99.9% by NDC Corporate Equity Fund IV, L.P. (NDC) and 0.1% by Saint Anthony's, L.L.C. (SAL).

SAL is 100% owned by Saint Anthony's Health Center (SAHC), an acute care hospital.

Various services such as payroll, fringe benefits and dietary are paid for by SAHC and billed monthly to SCV, without mark-up. Other expenses such as utilities, maintenance and security are billed to SCV by SAHC based on actual SAHC cost prorated over SCV's occupied square footage. SAHC is related to SCV due to its ownership of SAL, the General Partner. All amounts paid to SAHC by SCV are based on cost and were subject to negotiation with an audit by the NDC, the Limited Partner.

A detailed schedule of expenses is not attached, because the General Partner owns only a 0.1% interest in the provider.