

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>1000012</u></p> <p>Facility Name: <u>Saint Clares Villa</u></p> <p>Address: <u>915 East 5th St</u> <u>Alton</u> <u>62002</u> <small>Number City Zip Code</small></p> <p>County: <u>Madison</u></p> <p>Telephone Number: (<u>618</u>) <u>463-9000</u> Fax # <u>(618) 463-0995</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>04/08/02</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 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</u>) <u>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>01/01/13</u> to <u>12/31/13</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%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Sister M. Mikela, FSGM</u> (Title) <u>President & CEO Saint Anthony's Health System</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>See Accountant's Compilation Report Attached</u> (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></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>Sister M. Mikela, FSGM</u> (Title) <u>President & CEO Saint Anthony's Health System</u>	Paid Preparer	(Signed) <u>See Accountant's Compilation Report Attached</u> (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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Facility Name: Saint Clares Villa

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	18,382		310,535	328,917		328,917	1
2	Housekeeping, Laundry and Maintenance	55,286	4,639	127,230	187,155		187,155	2
3	Heat and Other Utilities			146,746	146,746		146,746	3
4	Other (specify): Security			42,302	42,302		42,302	4
5	TOTAL General Services	73,668	4,639	626,813	705,120		705,120	5
B. Health Care and Programs								
6	Health Care/ Personal Care	300,431	3,921		304,352		304,352	6
7	Activities and Social Services	25,276	2,922		28,198		28,198	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	325,707	6,843		332,550		332,550	9
C. General Administration								
10	Administrative and Clerical	104,337	2,446	179,517	286,300	(16,828)	269,472	10
11	Marketing Materials, Promotions and Advertising							11
12	Employee Benefits and Payroll Taxes			132,555	132,555		132,555	12
13	Insurance-Property, Liability and Malpractice			32,469	32,469		32,469	13
14	Other (specify):							14
15	TOTAL General Administration	104,337	2,446	344,541	451,324	(16,828)	434,496	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	503,712	13,928	971,354	1,488,994	(16,828)	1,472,166	16
Capital Expenses								
D. Ownership								
17	Depreciation			344,504	344,504		344,504	17
18	Interest			23,701	23,701		23,701	18
19	Real Estate Taxes			24,551	24,551		24,551	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			235	235		235	21
22	Other (specify): Amortization			119	119		119	22
23	TOTAL Ownership			393,110	393,110		393,110	23
24	GRAND TOTAL (Sum of lines 16 and 23)	503,712	13,928	1,364,464	1,882,104	(16,828)	1,865,276	24

Facility Name: Saint Clares Villa

Report Period Beginning 01/01/13 Ending: 12/31/13

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.27	\$ 33.34	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	7.78	13.13	3
4	Activity Director & Assistants	0.93	13.06	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	0.04	28.73	7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	2.77	9.59	10
11	Laundry			11
12	Managers	1.00	23.98	12
13	Other Administrative			13
14	Clerical	1.47	18.12	14
15	Marketing			15
16	Other Dining Room Assistant	0.91	8.30	16
17	Total (lines 1 thru 16)	16.17	\$	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
St. 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: Saint Clares Villa

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	\$	\$ 4,157,141	1
2											2
3			Construction in Progress		45,989						3
4											4
5											5
Improvement Type											
6	Beauty Shop			2003	3,685	134		134		1,512	6
7	Vinyl Flooring			2006	3,910	142		142		1,001	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)				\$ 9,673,345	\$ 344,504		\$ 344,504	\$	\$ 4,159,654	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	\$ 196,034	\$	\$	\$		\$ 196,034	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 196,034	\$	\$	\$		\$ 196,034	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: Saint Clares Villa

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	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		IHDA Trust Fund		X	Building & Improvements	7/19/01	\$ 750,000	\$ 569,833	8/1/41	0.0100	\$ 5,776	1
2		Madison County C.D.		X	Building & Improvements	Not Dated	300,000	300,000	10/1/41	0.0582	17,925	2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 1,050,000	\$ 869,833			\$ 23,701	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 1,050,000	\$ 869,833			\$ 23,701	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: Saint Clares Villa

Report Period Beginning: 01/01/13

Ending:

12/31/13

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,168	\$	1
2	Cash-Patient Deposits	2		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	300,815		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 343,021	\$	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	349,522		16
17	Accumulated Depreciation (book methods)	(4,355,757)		17
18	Deferred Charges	3,404		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): CIP	45,989		22
23	Other(specify): Oper. & Repl Reserves	310,267		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,827,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,170,313	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 20,600	\$	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	25,029		31
32	Accrued Interest Payable	18,466		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Due to Affiliates	995,823		35
36	Rent Received in Advance	5,190		36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,065,108	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	869,833		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)	\$ 869,833	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,934,941	\$	45
46	TOTAL EQUITY	\$ 4,235,372	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,170,313	\$	47

*(See instructions.)

Facility Name: Saint Clares Villa

Report Period Beginning: 01/01/13

Ending:

12/31/13

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	\$ 1,540,521	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,540,521	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	400	12
13	Interest and Other Investment Income	3	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 403	14
D. Other Revenue (specify):			
15	Application Fees	425	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 425	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,541,349	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	705,120	19
20	Health Care/ Personal Care	332,550	20
21	General Administration	451,324	21
B. Capital Expense			
22	Ownership	393,110	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)	\$ 1,882,104	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (340,755)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (340,755)	31

Saint Clare's Villa
SLF Cost Report - Adjustments
12/31/13

Attachment 1

<u>Adj #</u>	<u>Cost Center</u>		<u>Line</u>	<u>Col</u>	<u>Amount</u>
1	Administrative and Clerical	Groupers	10	5	(1,953)
	<i>To Eliminate Sales Tax Expense</i>				
2	Administrative and Clerical	Groupers	10	5	(14,875)
	<i>To Eliminate Bad Debt Expense</i>				
					<u><u>(16,828)</u></u>

Saint Clare's Villa
SLF Cost Report
Related Party Disclosure
December 31, 2013

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.

