FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0025346

Facility Name: Litle Sisters of the Poor

Address: 2325 N Lakewood Ave (Number) Chicago (City) 60614 (Zip Code)

County: Cook

Telephone Number: (773) 935-9600 **Fax #** (773)935-9614

HFS ID Number:

Date of Initial License for Current Owners: 5/1/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Catherine Uliasz **Telephone Number:** (773) 935-9600
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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)
(Type or Print Name) Sr. Ann Donnelly
(Title) Secretary

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deb Emerson, Principal
(Firm Name & Address) CliftonLarsonAllen, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 317-574-9707

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,449	145	329	18,923	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,449	145	329	18,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.03%

D. How many bed reserve days during this year were paid by the Department?
NONE (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 05/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/01980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 329

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	780,265	27,186	58,065	865,516		865,516	(127,362)	738,154			1
2	Food Purchase		250,971		250,971		250,971		250,971			2
3	Housekeeping	403,127	38,970	62,533	504,630		504,630		504,630			3
4	Laundry	117,322	13,962		131,284		131,284	(4,104)	127,180			4
5	Heat and Other Utilities			274,507	274,507		274,507	(57,461)	217,046			5
6	Maintenance	189,455	55,600	246,408	491,463		491,463	(106,291)	385,172			6
7	Other (specify):*											7
8	TOTAL General Services	1,490,169	386,689	641,513	2,518,371		2,518,371	(295,218)	2,223,153			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,949,201	119,034	179,907	3,248,142		3,248,142		3,248,142			10
10a	Therapy			134,634	134,634		134,634		134,634			10a
11	Activities	202,059	5,952		208,011		208,011		208,011			11
12	Social Services	54,597			54,597		54,597		54,597			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Chaplain		2,620	58,258	60,878		60,878		60,878			15
16	TOTAL Health Care and Programs	3,205,857	127,606	372,799	3,706,262		3,706,262		3,706,262			16
	C. General Administration											
17	Administrative			90,121	90,121		90,121		90,121			17
18	Directors Fees											18
19	Professional Services			342,348	342,348		342,348		342,348			19
20	Dues, Fees, Subscriptions & Promotions			63,691	63,691		63,691		63,691			20
21	Clerical & General Office Expenses	453,360	83,395	471,118	1,007,873		1,007,873	(346,349)	661,524			21
22	Employee Benefits & Payroll Taxes			1,036,367	1,036,367		1,036,367		1,036,367			22
23	Inservice Training & Education			20,260	20,260		20,260		20,260			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,439	52,439		52,439		52,439			26
27	Other (specify):* Marketing/Fundraising			153,522	153,522		153,522	(153,522)				27
28	TOTAL General Administration	453,360	83,395	2,229,866	2,766,621		2,766,621	(499,871)	2,266,750			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,149,386	597,690	3,244,178	8,991,254		8,991,254	(795,089)	8,196,165			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Litle Sisters of the Poor #0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			446,435	446,435		446,435	(57,456)	388,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,000	129,000		129,000	(129,000)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			64,400	64,400		64,400		64,400			35
36	Other (specify):*											36
37	**TOTAL Ownership**			639,835	639,835		639,835	(186,456)	453,379			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			10,145	10,145		10,145		10,145			39
40	Barber and Beauty Shops			5,695	5,695		5,695		5,695			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,569	214,569		214,569		214,569			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			230,409	230,409		230,409		230,409			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,149,386	597,690	4,114,422	9,861,498		9,861,498	(981,545)	8,879,953			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(57,456)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(346,349)	21		24
25	Fund Raising, Advertising and Promotional	(153,522)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(295,218)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (852,545)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(129,000)	32	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (129,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (981,545)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Litle Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sisters Non-SNF Dietray Costs	$ (127,362)	1	1
2	Sisters Non-SNF Laundry Costs	(4,104)	4	2
3	Sisters Non-SNF Plant Costs	(106,291)	6	3
4	Sisters Non-SNF Property Costs	(57,461)	5	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(295,218)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(127,362)	0	0	0	0	0	0	0	0	0	0	(127,362)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,104)	0	0	0	0	0	0	0	0	0	0	(4,104)	4
5	Heat and Other Utilities	(57,461)	0	0	0	0	0	0	0	0	0	0	(57,461)	5
6	Maintenance	(106,291)	0	0	0	0	0	0	0	0	0	0	(106,291)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(295,218)	0	0	0	0	0	0	0	0	0	0	(295,218)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(346,349)	0	0	0	0	0	0	0	0	0	0	(346,349)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(153,522)	0	0	0	0	0	0	0	0	0	0	(153,522)	27
28	TOTAL General Administration	(499,871)	0	0	0	0	0	0	0	0	0	0	(499,871)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(795,089)	0	0	0	0	0	0	0	0	0	0	(795,089)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litle Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(57,456)	0	0	0	0	0	0	0	0	0	0	(57,456)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(129,000)	0	0	0	0	0	0	0	0	0	0	(129,000)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(186,456)	0	0	0	0	0	0	0	0	0	0	(186,456)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(981,545)	0	0	0	0	0	0	0	0	0	0	(981,545)	45

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sr. Julie Horseman	BOD						1
2	Sr. Carolyn Martin	BOD						2
3	Sr. Ann Donnelly	BOD						3
4	Sr. Maria Pale	BOD						4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LSP-St. Joseph's Home for the Elderly	Palatine, IL	Little Sisters of the Poor - Chicago Province	Palatine, IL	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Windstream Internet	$ 25,590	LSP-Chicago Province	0.00%	$ 25,590	$	1
2	V	19	Blackbaud (Raiser's Edge) Software	2,050	LSP-Chicago Province	0.00%	2,050		2
3	V	21	Spam Filter/Email Encrytion	1,151	LSP-Chicago Province	0.00%	1,151		3
4	V	19	Computer IT Consulting	15,696	LSP-Chicago Province	0.00%	15,696		4
5	V	19	HR/Payroll Consulting	9,295	LSP-Chicago Province	0.00%	9,295		5
6	V	21	Supplies-Isolation Gowns	10,275	LSP-Chicago Province	0.00%	10,275		6
7	V	32	Interest Expense	129,000	LSP-Chicago Province	0.00%	129,000		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 193,057			$ 193,057	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Little Sisters of the Poor	X		Working Capital	None	Various	5,000,000	4,300,000	Various	3.0000	129,000	6
7	Chicago Province											7
8												8
9	TOTAL Facility Related						$ 5,000,000	$ 4,300,000			$ 129,000	9
	B. Non-Facility Related*											
10	Related Interest	X									(129,000)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (129,000)	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 4,300,000			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litle Sisters of the Poor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025346

CONTACT PERSON REGARDING THIS REPORT Catherine Uliasz

TELEPHONE (773) 935-9600 FAX #: (773)935-9614

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 117,137 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

50 Apartments/Independent Living Facilities

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		195,291	1979	$ 641,000	1
2					2
3	TOTALS	195,291		$ 641,000	3

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	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	
4	76		1980	1980	$ 8,261,076	$ 110,132	40	$ 110,132	$	$ 8,261,076	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Additions			1981	274,725						9
10	1982 Additions			1982	9,877						10
11	1983 Additions			1983	13,295						11
12	1984 Additions			1984	27,853						12
13	1985 Additions			1985	114,365						13
14	1986 Additions			1986	53,395						14
15	1988 Additions			1988	66,715						15
16	1989 Additions			1989	7,615						16
17	1990 Additions			1990	182,834						17
18	1991 Additions			1991	6,413						18
19	1996 Additions			1996	3,050						19
20	1997 Additions			1997	592,498						20
21	1998 Additions			1998	7,258						21
22	1999 Additions			1999	1,113,512						22
23	2000 Additions			2000	338,742						23
24	2001 Additions			2001	5,172						24
25	2002 Additions			2002	36,889						25
26	2003 Additions			2003	18,123						26
27	2008 Additions			2008	4,705						27
28	2011 Additions			2011	1,612						28
29	2013 Additions			2013	86,163						29
30	2014 Additions			2014	25,250						30
31	2016 Additions			2016	102,557						31
32	ADA Shower Room for 5th Floor			2017	19,569						32
33	Grease Trap for SNF Kitchen			2017	29,271						33
34	Bathtub Surrounds for 4 rooms on 3rd Floor			2017	7,777						34
35	Electrical&Mechanical Repair for 2 elevators			2018	4,185						35
36	Mechanical refrigeration repair for kitchen chiller			2018	6,870						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building masonry work	2018	$ 5,919	$ 148	40	$ 148	$	$ 370	37
38	Electric, plumbing, mechanical replacment for								38
39	coffee room/buffet on 1st floor	2019	12,198	152	40	152		152	39
40	Silicone Coating for Roof	2019	38,337	479	40	479		479	40
41	Overhead Garage Door	2019	2,553	128	10	128		128	41
42	Freezer Repair	2019	9,584	479	10	479		479	42
43	Cooler Repair	2019	2,396	120	10	120		120	43
44	Belden Street Wall Repair - Certified Masonry	2020	7,406	370	40	370		370	44
45	Parking Lot Repairs	2020	2,962	148	20	148		148	45
46	Plumbing Repair - Kitchen (faucets, fittings, pipes)	2020	3,028	151	10	151		151	46
47	HVAC Repair - new compressor in 2-in-1 freezer	2020	5,002	250	10	250		250	47
48	HVAC Repair - AC work in 5 story SNF	2020	14,451	723	10	723		723	48
49	HVAC Repair - 2nd floor South section of SNF	2020	8,922	446	10	446		446	49
50	Walk in Cooler Repair	2020	5,054	253	10	253		253	50
51	Chapel Woodwork Repair	2020	3,485	174	10	174		174	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,542,663	$ 114,153		$ 114,153	$	$ 8,265,319	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,542,663	$ 114,153		$ 114,153	$	$ 8,265,319	1
2									2
3	Capital Building Repair-Per P/A Desk Audit	1985	41,413		40		1,035	36,235	3
4	CBR-Tuckpointing Repair Work, Sewer & Door	1998	131,347		20			131,347	4
5	CBR-Door Elevator Plumbing & Heat Pump Repairs	2007	77,636		10			77,636	5
6	CBR-Roof Repair. Exterior Brick Work & HVAC AC Repair	2008	110,671		20		5,534	63,641	6
7	CBR-Exterior Brick Work. Equip, Electrical & Condenser Rpr	2009	31,512		20		1,576	16,548	7
8	CBR-Plumbing Electrical & HV AC Repairs	2010	22,125		20		1,106	10,507	8
9	CBR-Plumbing Disposal HV AC & Nursing Call Repairs	2011	17,736		20		887	7,539	9
10	CBR-Plumbing & HV AC Repairs	2012	17,027		10		1,703	12,772	10
11	CBR-Elevator HV AC. Plumbing & Electrical Repairs	2013	22,592		20		1,130	7,345	11
12	CBR-Parking Lot HV AC & Plumbing Repairs	2014	16,432		20		822	4,521	12
13	CBR-Electrical & Plumbing Repairs	2015	5,486		20		272	1,227	13
14	CBR-HVAC Repairs	2016	11,611		20		580	2,030	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	Financial Statement Depreciation			240,634		240,634		2,814,662	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,048,251	$ 354,787		$ 354,787	$ 14,645	$ 11,451,329	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 513,094	$ 27,253	$ 27,253	$	5 to 10	$ 394,890	71
72	Current Year Purchases	98,777	6,939	6,939		5 to 10		72
73	Fully Depreciated Assets					5 to 10		73
74	Current Year Disposals	(13,536)						74
75	TOTALS	$ 598,335	$ 34,192	$ 34,192	$		$ 394,890	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	01 Ford Taurus	2001	$ 16,957	$	$	$		$ 16,957	76
77										77
78										78
79										79
80	TOTALS			$ 16,957	$	$	$		$ 16,957	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,304,543	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 388,979	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 388,979	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,645	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,863,176	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation	$ 1,949,528	$ 52,406	$ 1,691,480	86
87	Equip - Convent Allocation	86,381	5,050	58,329	87
88	Vehicles - Convent Allocation	166,676		166,676	88
89					89
90					90
91	TOTALS	$ 2,202,585	$ 57,456	$ 1,916,485	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 19,649	92
93			93
94			94
95		$ 19,649	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 64,400 Description: Bunn Sure Immersion Coffee Maker & 10 Headphone Group Listening System
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Equipment Rental:

Total rental expense incurred during the reporting period for movable		
	Description of Rental Equip	Rental Expense for this Period.
1	Bunn Sure Immersion Coffee Maker	2,400
2	10-Headphone Group Listening System	1,100
3	Air Scrubber Rental - Thermflo	60,900
4		
		64,400

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	$		$ 62,115	$		$ 62,115	1
2	Licensed Speech and Language Development Therapist	10a	hrs			16,773			16,773	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			55,746			55,746	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 134,634	$		$ 134,634	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Litle Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 746,900	$	1
2	Cash-Patient Deposits	56,400		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (366,753))	528,138		3
4	Supply Inventory (priced at)	80,653		4
5	Short-Term Investments			5
6	Prepaid Insurance	25,600		6
7	Other Prepaid Expenses	43,565		7
8	Accounts Receivable (owners or related parties)	16,672		8
9	Other(specify): Employee Advance	(1,686)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,496,242	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	641,000		13
14	Buildings, at Historical Cost	12,768,413		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,249,782		16
17	Accumulated Depreciation (book methods)	(13,779,661)		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 (spe CIP	19,649		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,899,183	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,395,425	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 208,520	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	80,653		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,482		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,259		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,211,561		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,609,475	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,368,074		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,368,074	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,977,549	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,582,124)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,395,425	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,210,579)	1
2	Restatements (describe):		2
3	PY Adjustments	(415,907)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,626,486)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(955,638)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (955,638)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,582,124)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,630,912	1
2	Discounts and Allowances for all Levels	(255,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,375,571	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	205,945	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 205,945	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	989,627	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,875	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,001,502	23
	D. Non-Operating Revenue		
24	Contributions	3,908,248	24
25	Interest and Other Investment Income***	1,730	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,909,978	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Income	412,864	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 412,864	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,905,860	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,518,371	31
32	Health Care	3,706,262	32
33	General Administration	2,766,621	33
	B. Capital Expense		
34	Ownership	639,835	34
	C. Ancillary Expense		
35	Special Cost Centers	15,840	35
36	Provider Participation Fee	214,569	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,861,498	40
41	**Income before Income Taxes (line 30 minus line 40)****	(955,638)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (955,638)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 266,258	44
45	Private Pay - Net Inpatient Revenue	1,020	45
46	Medicare - Net Inpatient Revenue	159,484	46
47	Other-(specify)	2,948,809	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,375,571	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,064	$ 94,937	$ 46.00	1
2	Assistant Director of Nursing	2,100	2,100	85,968	40.94	2
3	Registered Nurses	12,391	12,391	411,382	33.20	3
4	Licensed Practical Nurses	18,834	18,834	561,332	29.80	4
5	CNAs & Orderlies	88,436	88,436	1,609,199	18.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,666	2,666	55,321	20.75	9
10	Activity Assistants	8,564	8,564	146,738	17.13	10
11	Social Service Workers	2,178	2,178	54,597	25.07	11
12	Dietician					12
13	Food Service Supervisor	2,657	2,657	67,005	25.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	45,594	45,594	713,260	15.64	15
16	Dishwashers					16
17	Maintenance Workers	8,998	8,998	189,455	21.06	17
18	Housekeepers	28,146	28,146	403,127	14.32	18
19	Laundry	7,392	7,392	117,322	15.87	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	20,349	20,349	453,360	22.28	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,013	2,013	35,875	17.82	31
32	Other Health C: MDS	2,425	2,425	91,833	37.87	32
33	Other(specify) Scheduler	2,277	2,277	58,675	25.77	33
34	TOTAL (lines 1 - 33)	257,084	257,084	$ 5,149,386 *	$ 20.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	188	$ 8,095	1-3	35
36	Medical Director	260	3,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	248	26,093	19-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Contracted Business (	215	9,844	19-3	46
47	Contracted Resident Accounts Rep	468	21,519	19-3	47
48	Contracted Administrator	634	64,446	19-3	48
49	TOTAL (lines 35 - 48)	2,013	$ 132,997		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 1,120	10-3	50
51	Licensed Practical Nurses	577	38,026	10-3	51
52	Certified Nurse Assistants/Aides	400	21,013	10-3	52
53	TOTAL (lines 50 - 52)	993	$ 60,159		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Two Sisters Acting as Administrator & Assistant	$ 15,750
Health Insurance for 12 months per Sister	15,327
Room & Board for 12 months per Sister	59,044
TOTAL (agree to Schedule V, line 17, col. 3)	$ 90,121
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LSP Chicago Province	Accounting/Other	$ 122,191
Carlin & Associates, Ltd	Other	400
RHP Risk Management Inc	Other	400
Stellar Support Services LLC	Other	350
Lauer, Sbarbaro Associates	Other	12,960
Polaris Group	Other	7,018
Plante Moran Living Forward	Other	47,625
ADP	Accounting	26,013
Healthcare Resource Group	Accounting	45,932
Nixon Peabody	Legal	2,946
E. Vaccariello & Company LLP	Accounting	33,400
Mueller & Co LLP	Accounting	43,113
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 342,348

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,865
Unemployment Compensation Insurance	22,691
FICA Taxes	393,968
Employee Health Insurance	411,548
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	93,455
Employee Physicals	12,026
Employee Dental Insurance	12,318
Employee Life Insurance	2,685
Employee Vision Insurance	1,126
Other	4,685
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,367

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	32,349
Health Care Worker Background Check	
(Indicate # of checks performed 42)	1,259
Patient Background Checks	
Public Relations Expense	11,728
Licenses & Fees	10,886
Dues & memberships	7,469
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,691

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LeadingAge IL - $3,847

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 22,333 Line 2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 214,569
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NO Indicate the amount. $ 0

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 25%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: E. Vaccariello & Company PA

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.