

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

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.

<p>I. IDPH Facility ID Number: <u>0025346</u></p> <p>Facility Name: <u>Little Sisters of the Poor</u></p> <p>Address: <u>2325 N. Lakewood</u> <u>Chicago</u> <u>60614</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 935-9600</u> Fax # <u>(773) 935-9614</u></p> <p>IDPA ID Number: <u>36-2482272 / 001</u></p> <p>Date of Initial License for Current Owners: <u>05/01/80</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></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>Mother Patricia Gertrude Friel</u> Telephone Number: <u>(773) 935-9600</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c3</u>	<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>01/01/2002</u> to <u>12/31/2002</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 data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Mother Patricia Gertrude Friel</u></td> </tr> <tr> <td data-bbox="1144 747 1281 828"></td> <td data-bbox="1281 747 1921 828">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 909">(Signed) _____ (Date) _____ (Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u></td> </tr> <tr> <td data-bbox="1144 909 1281 1039"></td> <td data-bbox="1281 909 1921 1039">(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>617 E Golf Road, Suite 107, Arlington Heights, IL 60005</u> (Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 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>Mother Patricia Gertrude Friel</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u>		(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>617 E Golf Road, Suite 107, Arlington Heights, IL 60005</u> (Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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Facility Name & ID Number Little Sisters of the Poor

0025346 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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

No Change

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,345</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>	<u>28,835</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	<u>20,499</u>	<u>896</u>		<u>21,395</u>	10
11	ICF/DD					11
12	SC		<u>1,460</u>		<u>1,460</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,499</u>	<u>2,356</u>		<u>22,855</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.26%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold 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 NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES 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 Date 05/01/1980 NO

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	352,925	26,321	121,510	500,756	500,756		500,756			1
2	Food Purchase		209,617		209,617	209,617	(110,516)	99,101			2
3	Housekeeping	245,806	21,819		267,625	267,625		267,625			3
4	Laundry	97,814	12,963		110,777	110,777	(6,868)	103,909			4
5	Heat and Other Utilities			296,730	296,730	296,730	(95,540)	201,190			5
6	Maintenance	170,448	43,594	170,020	384,062	384,062	(24,500)	359,562			6
7	Other (specify):*			87,958	87,958	87,958		87,958			7
8	TOTAL General Services	866,993	314,314	676,218	1,857,525	1,857,525	(237,424)	1,620,101			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,165,062	29,126	117,741	1,311,929	1,311,929		1,311,929			10
10a	Therapy	34,152	78	1,071	35,301	35,301		35,301			10a
11	Activities	67,045	17,603	53,435	138,083	138,083		138,083			11
12	Social Services	44,338			44,338	44,338		44,338			12
13	Nurse Aide Training										13
14	Program Transportation			1,983	1,983	1,983		1,983			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,310,597	46,807	174,230	1,531,634	1,531,634		1,531,634			16
	C. General Administration										
17	Administrative			15,000	15,000	15,000		15,000			17
18	Directors Fees										18
19	Professional Services			68,655	68,655	68,655	(7,084)	61,571			19
20	Dues, Fees, Subscriptions & Promotions			38,552	38,552	38,552	(20,947)	17,605			20
21	Clerical & General Office Expenses	197,907	9,846	165,856	373,609	373,609	(15,189)	358,420			21
22	Employee Benefits & Payroll Taxes			553,386	553,386	553,386		553,386			22
23	Inservice Training & Education			3,867	3,867	3,867		3,867			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			5,950	5,950	5,950		5,950			25
26	Insurance-Prop.Liab.Malpractice			25,272	25,272	25,272	(3,253)	22,019			26
27	Other (specify):*										27
28	TOTAL General Administration	197,907	9,846	876,538	1,084,291	1,084,291	(46,473)	1,037,818			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,375,497	370,967	1,726,986	4,473,450	4,473,450	(283,897)	4,189,553			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

Little Sisters of the Poor

#0025346

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation				512,429		512,429	(29,137)	483,292			30
31	Amortization of Pre-Op. & Org.			512,429								31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			512,429	512,429		512,429	(29,137)	483,292			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,160		6,160		6,160		6,160			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,253	43,253		43,253		43,253			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,160	43,253	49,413		49,413		49,413			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,375,497	377,127	2,282,668	5,035,292		5,035,292	(313,034)	4,722,258			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 Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(110,516)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,100)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,868)	4		8
9	Non-Straightline Depreciation	(29,137)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(15,189)	21		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	(93,440)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	14,241	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(3,253)	26		21
22	Special Legal Fees & Legal Retainers	(7,084)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,947)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(38,741)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (313,034)		\$	30

OHF 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	2	
		Amount	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (313,034)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Little Sisters of the Poor

ID# 0025346
 Report Period Beginning: 01/01/2002
 Ending: 12/31/2002

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Line 15 - Non-Care Related Owner's Transactions	\$ (38,741)	6
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			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	(38,741)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Sisters of the Poor

0025346 Report Period Beginning:

01/01/2002 Ending: 12/31/2002

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(110,516)	0	0	0	0	0	0	0	0	0	0	(110,516)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,868)	0	0	0	0	0	0	0	0	0	0	(6,868)	4
5	Heat and Other Utilities	(95,540)	0	0	0	0	0	0	0	0	0	0	(95,540)	5
6	Maintenance	(24,500)	0	0	0	0	0	0	0	0	0	0	(24,500)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(237,424)	0	0	0	0	0	0	0	0	0	0	(237,424)	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	Nurse Aide 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	(7,084)	0	0	0	0	0	0	0	0	0	0	(7,084)	19
20	Fees, Subscriptions & Promotions	(20,947)	0	0	0	0	0	0	0	0	0	0	(20,947)	20
21	Clerical & General Office Expenses	(15,189)	0	0	0	0	0	0	0	0	0	0	(15,189)	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	(3,253)	0	0	0	0	0	0	0	0	0	0	(3,253)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(46,473)	0	0	0	0	0	0	0	0	0	0	(46,473)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(283,897)	0	0	0	0	0	0	0	0	0	0	(283,897)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Sisters of the Poor# 0025346

Report Period Beginning:

01/01/2002 Ending:12/31/2002

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(29,137)	0	0	0	0	0	0	0	0	0	0	(29,137) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 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	(29,137)	0	0	0	0	0	0	0	0	0	0	(29,137) 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)	(313,034)	0	0	0	0	0	0	0	0	0	0	(313,034) 45

Facility Name & ID Number Little Sisters of the Poor# 0025346

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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. 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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V		\$				\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ -0-				\$ -0-	\$ * -0-	14

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								TOTAL	\$ -0-		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 Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

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

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

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

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				\$ -0-	\$ -0-		\$ -0-	25

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

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	NONE						\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6	NONE											6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$			\$	9								
	B. Non-Facility Related*																			
10	NONE											10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$	\$			\$	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # _____

* 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 **Little Sisters of the Poor**# **0025346** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$	-0-		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.)		\$	-0-		2
3. Under or (over) accrual (line 2 minus line 1).		\$	-0-		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	-0-		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.)		\$	-0-		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.)		\$	-0-		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	-0-		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	-0-	8		
	1998	-0-	9		
	1999	-0-	10		
	2000	-0-	11		
	2001	-0-	12		
				FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2001	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Little Sisters of the Poor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025346

CONTACT PERSON REGARDING THIS REPORT Mother Patricia Gertrude Friel

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 2001 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 2001.

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

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 & 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 a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Little Sisters of the Poor

0025346 Report Period Beginning:

01/01/2002 Ending:

12/31/2002

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? (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? (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

50 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. Expenses for the apartments are NOT included in this cost report.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/ANature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Existing Structure	195,291	1979	\$ 558,496	1
2					2
3	TOTALS	195,291		\$ 558,496	3

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	79	1980	1980	\$ 7,986,351	\$ 229,150	40	\$ 199,659	\$ (29,491)	\$ 4,517,929	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Fencing & Electric Gates, Parking Misc Electric & Landscaping	1981		274,725	7,883	40	6,868	(1,015)	147,769	9
10	Sliding Gates, Misc Electric & Decorating	1982		9,877	283	40	247	(36)	5,064	10
11	Building Renovation	1983		10,031	288	40	251	(37)	4,906	11
12	Land Improvement - Landscaping	1983		3,265	187	20	163	(24)	3,181	12
13	Construction of Beauty Shop	1984		27,853	799	40	696	(103)	12,887	13
14	Kitchen Tile, Lighting, Ice Cream Parlor, Reception Area, Closets	1985		41,873	1,201	40	1,047	(154)	18,332	14
15	Land Improvement - Covered Walkway, Concrete Patios	1985		72,492	4,160	20	3,625	(535)	63,467	15
16	Land Improvement - Parking Lot Lights, Park Area	1986		12,805	735	20	640	(95)	10,568	16
17	New Garage	1986		40,590	1,165	40	1,015	(150)	16,783	17
18	Chapel Renovation	1988		66,715	1,914	40	1,668	(246)	24,193	18
19	Electric Work for New Garage	1989		7,615	219	40	191	(28)	2,578	19
20	Garage Completion, Repiping Storage Facility	1990		154,974	4,447	40	3,875	(572)	48,455	20
21	Land Improvement - Paving/Resurface Parking Lots	1990		27,860	1,599	20	1,393	(206)	17,421	21
22	Boiler Room Floor Drains	1991		6,413	184	40	160	(24)	1,840	22
23	Land Improvement - New Sidewalks	1996		3,050	175	20	152	(23)	988	23
24	Senior Center, Physical Therapy & Elevator Renovation	1997		332,952	9,553	40	8,324	(1,229)	45,782	24
25	Walkway Renovation	1997		222,446	6,383	40	5,561	(822)	30,586	25
26	Combining of Rooms and Room Conversions	1997		37,098	1,064	40	927	(137)	5,099	26
27	Senior Center and Physical Therapy	1998		7,258	208	40	182	(26)	819	27
28	Kitchen Renovation	1999		711,148	20,404	40	17,779	(2,625)	62,226	28
29	Window Replacements	1999		239,657	6,876	40	5,991	(885)	20,969	29
30	2nd Floor Room Renovations	1999		162,707	4,670	40	4,068	(602)	14,238	30
31	Land Improvement - Brick Paving of Second Courtyard	2000		16,555	950	20	828	(122)	2,070	31
32	Window Replacements	2000		271,260	7,783	40	6,781	(1,002)	16,952	32
33	Auditorium Roof	2000		50,927	1,461	40	1,272	(189)	3,180	33
34	Two New Electric Front Doors	2001		2,645	76	40	66	(10)	99	34
35	Land Improvement - Concrete Walk and Base	2001		2,527	146	20	126	(20)	189	35
36										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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Front Door Handicap Access	2002	\$ 479	\$ 7	40	\$ 6	\$ (1)	\$ 6	37	
38	Kitchen Main Grease Trap Replacement	2002	10,443	150	40	131	(19)	131	38	
39	Roof Replacements	2002	25,966	372	40	325	(47)	325	39	
40									40	
41	Capital Building Repair - Per P/A Desk Audit	1985	41,413		40	1,035	1,035	18,640	41	
42	Capital Building Repair - Per P/A Desk Audit	1986	42,062		20	2,103	2,103	35,769	42	
43	Capital Building Repair - Exterior Doors	1995	3,986		10	399	399	3,192	43	
44	CBR - Window, Door Gate, Smoke Detect, Heat Pump	1997	40,893		5	8,179	8,179	44,984	44	
45	CBR - Tuckpointing, Repair Work, Sewer & Doors	1998	131,347		20	6,567	6,567	29,552	45	
46	Capital Building Repair - Tank Removal	1999	10,761		5	2,152	2,152	7,532	46	
47	CBR - Electric Alt, Chiller and Fire System Repair	2000	17,825		5	3,565	3,565	8,912	47	
48	CBR - Heat Pump, Door, Flooring, Drapes, Signs and Heater	2001	47,182		5	9,436	9,436	14,154	48	
49	CBR - Flooring, Elec, Plumbing, Kitchen Rprs & Seal Coating	2002	33,755		5	3,376	3,376	3,376	49	
50									50	
51									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)		\$ 11,209,781	\$ 314,492		\$ 310,829	\$ (3,663)	\$ 5,265,143	70	

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (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	95 Dodge Van	1994	\$ 27,745	\$	\$	\$	4	\$ 27,745	76
77	Care Use	96 Chevy Bus	1996	45,374				4	45,374	77
78	Care Use	96 Buick 4dr	1996	11,784				4	11,784	78
79	Care Use	97 Dodge Maxi Van	1997	16,557				4	16,557	79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	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 Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,499,190	\$ 178,589	\$ 155,604	\$ (22,985)	10 Years	\$ 661,830	71
72	Current Year Purchases	77,076	4,423	3,854	(569)	10 Years	3,854	72
73	Fully Depreciated Assets	605,445				10 Years	605,445	73
74								74
75	TOTALS	\$ 2,181,711	\$ 183,012	\$ 159,458	\$ (23,554)		\$ 1,271,129	75

D. Vehicle Depreciation (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	\$ 4,866	\$ 4,239	\$ (627)	4	\$ 6,359	76
77	Care Use	01 Ford F150 w/PI & Spdr	2001	26,618	7,637	6,655	(982)	4	9,982	77
78	Care Use	03 Toyota Camry	2002	16,884	2,422	2,111	(311)	4	2,111	78
79										79
80	TOTALS			\$ 161,919	\$ 14,925	\$ 13,005	\$ (1,920)		\$ 119,912	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)	\$ 14,111,907	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 512,429	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 483,292	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,137)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,656,184	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 Various	\$ 1,601,262	\$ 40,475	\$ 780,944	86
87	Equip - Convent Allocation Various	322,261	23,554	187,758	87
88	Vehicles - Convent Allocation Var	23,918	1,920	17,712	88
89					89
90					90
91	TOTALS	\$ 1,947,441	\$ 65,949	\$ 986,414	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	\$	92
93			93
94			94
95		\$	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 Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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 Date of Lease	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

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. _____/2003 \$ _____
13. _____/2004 \$ _____
14. _____/2005 \$ _____

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: _____ *

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: \$ _____ Description: _____

(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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	TOTALS	\$ -0-	\$ -0-	\$ -0-	\$ -0-
10	SUM OF line 9, col. 1 and 2 (e)	\$ -0-			

C. CONTRACTUAL INCOME

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

\$ -0-

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	-0-

- (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 aide 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 aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39-2	visits				6,160		6,160	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	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 6,160		\$ 6,160	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 421,050	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	491,375		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	956,913		5
6	Prepaid Insurance	29,141		6
7	Other Prepaid Expenses	3,724		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	162,661		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,064,864	\$	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	12,441,819		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,689,809		16
17	Accumulated Depreciation (book methods)	(7,476,487)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,296,141	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,361,005	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,622	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,775		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			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)	\$ 177,397	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 177,397	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,183,608	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,361,005	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,064,919	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,064,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(865,173)	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	(16,138)	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)	\$ (881,311)	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)	\$ 10,183,608	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,651,180	1
2	Discounts and Allowances for all Levels	(239,259)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,411,921	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	1,727,674	24
25	Interest and Other Investment Income***	15,335	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,743,009	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees (Adjusted Out on Sch V)	15,189	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,189	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,170,119	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,857,525	31
32	Health Care	1,531,634	32
33	General Administration	1,084,291	33
B. Capital Expense			
34	Ownership	512,429	34
C. Ancillary Expense			
35	Special Cost Centers	6,160	35
36	Provider Participation Fee	43,253	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,035,292	40
41	Income before Income Taxes (line 30 minus line 40)**	(865,173)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (865,173)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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.

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,917	2,182	\$ 65,738	\$ 30.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,620	13,755	328,319	23.87	3
4	Licensed Practical Nurses	5,405	6,276	132,474	21.11	4
5	Nurse Aides & Orderlies	40,962	47,845	621,539	12.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,175	2,175	34,152	15.70	8
9	Activity Director	2,280	2,352	33,066	14.06	9
10	Activity Assistants	3,196	3,693	33,979	9.20	10
11	Social Service Workers	1,659	1,806	44,338	24.55	11
12	Dietician					12
13	Food Service Supervisor	1,915	1,973	28,525	14.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,220	34,483	324,400	9.41	15
16	Dishwashers					16
17	Maintenance Workers	8,231	10,030	170,448	16.99	17
18	Housekeepers	21,561	24,763	245,806	9.93	18
19	Laundry	9,085	10,419	97,814	9.39	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,248	14,606	197,907	13.55	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	1,397	1,453	16,992	11.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,871	177,811	\$ 2,375,497 *	\$ 13.36	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	118	\$ 4,130	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	89	2,671	10-3	39
40	Physical Therapy Consultant	22	1,071	10A-3	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	229	\$ 7,872		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Little Sisters of the Poor

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Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 22,763	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,134	Advertising: Employee Recruitment	7,284	
				FICA Taxes	181,726	Health Care Worker Background Check (Indicate # of checks performed <u>39</u>)	573	
				Employee Health Insurance	260,531	Public Relations	20,947	
				Employee Meals		Subscriptions	1,600	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees	1,040	
				Retirement Plan	59,856	Dues - Life Services Network of IL	3,847	
				Employee Physicals	4,376	Dues - Buying Service	2,511	
						Dues - Misc	750	
						Less: Public Relations Expense	(20,947)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 553,386	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,605	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Stipend for Two Sisters Acting as Administrator and Assistant Administrator at \$500 For 6 Months Per Sister and at \$750 For 6 Months Per Sister			15,000				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 15,000				In-State Travel	
C. Professional Services								
Vendor/Payee	Type		Amount					
R. E. Harrington	Unemploy Comp Consult		393					
ADP	Payroll Processing		12,653					
Varey & Vaccariello CPAs PC	Accounting and Auditing		33,863					
Jackson Lewis Schnitzler	Legal (Care Related)		14,314					
Katten, Muchin & Zavis	Legal (Care Related)		348					
O'Keefe Ashenden Lyons & Ward	Legal (Non-Care Related)		7,084					
NOTE: Non-Care Related Legal Adjusted Out of Schedule V, Line 19 (See Page 5, Line 22)								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 68,655	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repair A/C Shaft	04/99	\$ 2,382	3 Yrs	\$ 596	\$ 794	\$ 794	\$ 198	\$	\$	\$	\$
2	Repair Boiler #2	05/2000	2,315	3 Yrs		514	772	772	257			
3	Plumbing Repair	06/2000	2,290	3 Yrs		446	763	763	318			
4	Painting	08/2000	5,929	3 Yrs		824	1,976	1,976	1,153			
5	Plumbing Repair	09/2000	1,713	3 Yrs		190	571	571	381			
6	Painting	10/2000	11,470	3 Yrs		956	3,823	3,823	2,868			
7	Painting	01/2001	3,594	3 Yrs			1,198	1,198	1,198			
8	Painting	02/2001	13,180	3 Yrs			4,027	4,393	4,393	367		
9	Repair Kitchen HVAC	06/2001	1,650	3 Yrs			321	550	550	229		
10	Painting	10/2001	3,764	3 Yrs			314	1,255	1,255	940		
11	Repairs to HVAC Equip	11/2001	1,818	3 Yrs			101	606	606	505		
12	Repair to Heat Pump	10/2002	1,637	3 Yrs				15	546	546	530	
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 51,742		\$ 596	\$ 3,724	\$ 14,660	\$ 16,120	\$ 13,525	\$ 2,587	\$ 530	\$

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

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? No
If YES, give association name and amount. N/A
- (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? N/A
- (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? N/A
- (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. \$ 4,762 Line 10
- (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. N/A
- (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 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 of Public Aid during this cost report period. \$ 43,253
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 of Public Aid, 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% for
d. Have vehicle usage logs been maintained? Yes
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: Varey & Vaccariello CPAs PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.