

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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.

I. IDPH Facility ID Number: 0025346

Facility Name: Little Sisters of the Poor

Address: 2325 North Lakewood Avenue Chicago 60614
 Number City Zip Code

County: Cook

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

IDPA ID Number: 36-2482272 / 001

Date of Initial License for Current Owners: 05/01/80

Type of Ownership:

<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	

In the event there are further questions about this report, please contact:
Name: Mother Margaret Patricia Lennon **Telephone Number:** (773) 935-9600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 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) Mother Margaret Patricia Lennon
 (Title) President

Paid Preparer

(Signed) _____ (Date) _____
 (Print Name and Title) Elizabeth Vaccariello
Vice President
 (Firm Name & Address) Varey & Vaccariello CPAs PC
617 E Golf Road, Suite 107, Arlington Heights, IL 60005
 (Telephone) (847) 228-6977 Fax # (847) 228-0317

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 Little Sisters of the Poor

0025346 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 N/A

	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>25</u>	Skilled (SNF)	<u>25</u>	<u>9,125</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	<u>628</u>			<u>628</u>	8
9	SNF/PED					9
10	ICF	<u>23,627</u>	<u>805</u>		<u>24,432</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,255</u>	<u>805</u>		<u>25,060</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.34%

D. How many bed-hold days during this year were paid by the Department? 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: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	380,574	38,404	28,998	447,976		447,976		447,976			1
2	Food Purchase		192,888		192,888		192,888	(116,521)	76,367			2
3	Housekeeping	266,069	25,225		291,294		291,294		291,294			3
4	Laundry	98,741	12,700	12,171	123,612		123,612	(3,985)	119,627			4
5	Heat and Other Utilities			367,256	367,256		367,256	(110,936)	256,320			5
6	Maintenance	175,490	59,785	158,914	394,189		394,189	(7,558)	386,631			6
7	Other (specify):*			104,304	104,304		104,304		104,304			7
8	TOTAL General Services	920,874	329,002	671,643	1,921,519		1,921,519	(239,000)	1,682,519			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,461,868	60,158	188,825	1,710,851		1,710,851		1,710,851			10
10a	Therapy			3,595	3,595		3,595		3,595			10a
11	Activities	68,959	16,494	100,536	185,989		185,989		185,989			11
12	Social Services	27,074			27,074		27,074		27,074			12
13	CNA Training											13
14	Program Transportation			4,379	4,379		4,379		4,379			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,557,901	76,652	300,335	1,934,888		1,934,888		1,934,888			16
	C. General Administration											
17	Administrative			18,000	18,000		18,000		18,000			17
18	Directors Fees											18
19	Professional Services			44,781	44,781		44,781		44,781			19
20	Dues, Fees, Subscriptions & Promotions			43,274	43,274		43,274	(27,757)	15,517			20
21	Clerical & General Office Expenses	221,736	18,893	201,941	442,570		442,570	(18,000)	424,570			21
22	Employee Benefits & Payroll Taxes			676,085	676,085		676,085		676,085			22
23	Inservice Training & Education			1,957	1,957		1,957		1,957			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			13,136	13,136		13,136		13,136			25
26	Insurance-Prop.Liab.Malpractice			43,117	43,117		43,117	(5,549)	37,568			26
27	Other (specify):* Bad Debts			534	534		534	(534)				27
28	TOTAL General Administration	221,736	18,893	1,042,825	1,283,454		1,283,454	(51,840)	1,231,614			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,700,511	424,547	2,014,803	5,139,861		5,139,861	(290,840)	4,849,021			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: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			504,671	504,671		504,671	(25,138)	479,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,431	15,431		15,431	(15,431)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			520,102	520,102		520,102	(40,569)	479,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,356		8,356		8,356		8,356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		8,356	41,610	49,966		49,966		49,966			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,700,511	432,903	2,576,515	5,709,929		5,709,929	(331,409)	5,378,520			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: 01/01/2005

Ending: 12/31/2005

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	(116,521)	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	(3,985)	4		8
9	Non-Straightline Depreciation	(25,138)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(18,000)	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	(108,836)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	845	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(5,549)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(534)	27		24
25	Fund Raising, Advertising and Promotional	(27,757)	20		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 See Page 5A & Page 5B	(8,403)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (315,978)		\$	30

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)	(15,431)	32	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,431)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (331,409)		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

OHF USE ONLY					
48		49		50	51
					52

Little Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Line 15 - Non-Care Related Owner's Transactions	\$ (8,403)	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	(8,403)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	(116,521)	0	0	0	0	0	0	0	0	0	0	(116,521)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,985)	0	0	0	0	0	0	0	0	0	0	(3,985)	4
5	Heat and Other Utilities	(110,936)	0	0	0	0	0	0	0	0	0	0	(110,936)	5
6	Maintenance	(7,558)	0	0	0	0	0	0	0	0	0	0	(7,558)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(239,000)	0	0	0	0	0	0	0	0	0	0	(239,000)	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	(27,757)	0	0	0	0	0	0	0	0	0	0	(27,757)	20
21	Clerical & General Office Expenses	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	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	(5,549)	0	0	0	0	0	0	0	0	0	0	(5,549)	26
27	Other (specify):*	(534)	0	0	0	0	0	0	0	0	0	0	(534)	27
28	TOTAL General Administration	(51,840)	0	0	0	0	0	0	0	0	0	0	(51,840)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(290,840)	0	0	0	0	0	0	0	0	0	0	(290,840)	29

STATE OF ILLINOIS

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(25,138)	0	0	0	0	0	0	0	0	0	0	(25,138)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,431)	0	0	0	0	0	0	0	0	0	0	(15,431)	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	(40,569)	0	(40,569)	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)	(331,409)	0	(331,409)	45									

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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
		LSP - St. Joseph's Home for the Elderly	Palatine, IL	Little Sisters of the Poor - Chicago Province, Inc.	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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	32 Interest Expense	\$ 15,431	Little Sisters of the Poor - Chicago Province, Inc.		\$	\$ (15,431)	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		\$ 15,431			\$	\$ * (15,431)	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:

01/01/2005

Ending:

12/31/2005

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	\$		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:

01/01/2005

Ending:

2/31/2005

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	Little Sisters of the Poor											6
7	- Chicago Province, Inc.	X		Working Capital	NONE	12/13/04	300,000	300,000	12/13/09	0.0300	9,513	7
8	LSP - Chicago Province, Inc.	X		Working Capital	NONE	05/05/05	300,000	300,000	05/05/10	0.0300	5,918	8
9	TOTAL Facility Related						\$ 600,000	\$ 600,000			\$ 15,431	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)						\$ 600,000	\$ 600,000			\$ 15,431	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 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 2005 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:				
2000	_____	8		
2001	_____	9		
2002	_____	10		
2003	_____	11		
2004	_____	12		
			FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004	\$		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:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 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 Margaret Patricia Lennon

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 2004 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 2004.

(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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Little Sisters of the Poor

0025346 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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

Nature 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	<u>Existing Structure</u>	<u>195,291</u>	<u>1979</u>	<u>\$ 558,496</u>	1
2					2
3	TOTALS	195,291		\$ 558,496	3

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

	1 Beds*	FOR OHF 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	\$ 7,986,351	\$ 229,150	40	\$ 199,659	\$ (29,491)	\$ 5,116,906	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	6,869	(1,014)	168,374	9
10		Sliding Gates, Misc Electric & Decorating		1982	9,877	283	40	247	(36)	5,805	10
11		Building Renovation		1983	10,031	288	40	251	(37)	5,659	11
12		Land Improvement - Landscaping		1983	3,265		20			3,265	12
13		Construction of Beauty Shop		1984	27,853	799	40	696	(103)	14,975	13
14		Kitchen Tile, Lighting, Ice Cream Parlor, Reception Area, Closets		1985	41,873	1,201	40	1,047	(154)	21,473	14
15		Land Improvement - Covered Walkway, Concrete Patios		1985	72,492	2,080	20	1,695	(385)	72,492	15
16		Land Improvement - Parking Lot Lights, Park Area		1986	12,805	735	20	640	(95)	12,488	16
17		New Garage		1986	40,590	1,165	40	1,015	(150)	19,828	17
18		Chapel Renovation		1988	66,715	1,914	40	1,668	(246)	29,197	18
19		Electric Work for New Garage		1989	7,615	219	40	191	(28)	3,151	19
20		Garage Completion, Repiping Storage Facility		1990	154,974	4,447	40	3,875	(572)	60,080	20
21		Land Improvement - Paving/Resurface Parking Lots		1990	27,860	1,599	20	1,393	(206)	21,600	21
22		Boiler Room Floor Drains		1991	6,413	184	40	160	(24)	2,320	22
23		Land Improvement - New sidewalks		1996	3,050	175	20	152	(23)	1,444	23
24		Senior Center, Physical Therapy & Elevator Renovation		1997	332,952	9,553	40	8,324	(1,229)	70,754	24
25		Walkway Renovation		1997	222,446	6,383	40	5,561	(822)	47,269	25
26		Combining of Rooms and Room Conversions		1997	37,098	1,064	40	927	(137)	7,880	26
27		Senior Center and Physical Therapy		1998	7,258	208	40	182	(26)	1,365	27
28		Kitchen Renovation		1999	711,148	20,404	40	17,779	(2,625)	115,563	28
29		Window Replacements		1999	239,657	6,876	40	5,991	(885)	38,942	29
30		2nd Floor Room Renovations		1999	162,707	4,670	40	4,069	(601)	26,443	30
31		Land Improvement - Brick Paving of Second Courtyard		2000	16,555	950	20	828	(122)	4,554	31
32		Window Replacements		2000	271,260	7,783	40	6,781	(1,002)	37,295	32
33		Auditorium Roof		2000	50,927	1,461	40	1,272	(189)	6,996	33
34		Two New Electric Front Doors		2001	2,645	76	40	66	(10)	297	34
35		Land Improvement - Concrete Walk and Base		2001	2,527	145	20	126	(19)	567	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

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	\$ 14	40	\$ 12	\$ (2)	\$ 42	37
38	Kitchen Main Grease Trap Replacement	2002	10,443	300	40	261	(39)	914	38
39	Roof Replacements	2002	25,966	745	40	649	(96)	2,272	39
40	Land Improvement - Parking Lot Lights, EE Parking Lot	2003	18,123	1,040	20	906	(134)	2,265	40
41									41
42									42
43									43
44	Capital Building Repair - Per P/A Desk Audit	1985	41,413		40	1,035	1,035	21,745	44
45	Capital Building Repair - Per P/A Desk Audit	1986	42,062		20	2,103	2,103	42,078	45
46	CBR - Tuckpointing, Repair Work, Sewer & Doors	1998	131,347		20	6,567	6,567	49,253	46
47	CBR - Electric Alt, Chiller and Fire System Repair	2000	17,825		5	3,565	3,565	19,607	47
48	CBR - Heat Pump, Door, Flooring, Drapes, Signs and Heater	2001	47,182		5	9,436	9,436	42,462	48
49	CBR - Flooring, Elec, Plumbing, Kitchen Rprs & Seal Coating	2002	33,755		5	6,751	6,751	23,629	49
50	CBR - Auto, Windows, Fl, Boiler, K, SD & Plumb Rprs	2003	28,582		5	5,716	5,716	14,290	50
51	CBR - Various HVAC Repairs and Sidewalk Repairs	2004	20,124		5	4,025	4,025	6,037	51
52	CBR - Door Alarms and Fluid Cooler Basin	2005	7,322		5	732	732	732	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)		\$ 11,228,292	\$ 313,794		\$ 313,222	\$ (572)	\$ 6,142,308	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	97 Buick 4dr	1996	11,784				4	11,784	77
78	Care Use	01 Ford Taurus	2001	16,957	2,433	2,120	(313)	4	16,957	78
79	Care Use	01 Ford F150 w/Pl & Spdr	2001	26,618	3,819	3,326	(493)	4	26,618	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: 01/01/2005 Ending: 12/31/2005

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	\$ 1,444,747	\$ 166,304	\$ 144,901	\$ (21,403)	10 Years	\$ 877,580	71
72	Current Year Purchases	14,959	1,340	1,167	(173)	10 Years	1,167	72
73	Fully Depreciated Assets	530,666				10 Years	530,666	73
74								74
75	TOTALS	\$ 1,990,372	\$ 167,644	\$ 146,068	\$ (21,576)		\$ 1,409,413	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	03 Toyota Camry	2002	\$ 16,884	\$ 4,844	\$ 4,221	\$ (623)	4	\$ 14,774	76
77	Care Use	03 Ford Allstar Van	2003	22,915	6,575	5,729	(846)	4	14,322	77
78	Care Use	04 Ford Truck Econoline	2003	19,384	5,562	4,847	(715)	4	12,116	78
79										79
80	TOTALS			\$ 142,287	\$ 23,233	\$ 20,243	\$ (2,990)		\$ 124,316	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)		\$ 13,919,447	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 504,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 479,533	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (25,138)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 7,676,037	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	\$ 1,603,939	\$ 40,502	\$ 902,615	86
87	Equip - Convent Allocation Various	293,999	21,576	208,184	87
88	Vehicles - Convent Allocation Var	21,018	2,990	18,362	88
89					89
90					90
91	TOTALS	\$ 1,918,956	\$ 65,068	\$ 1,129,161	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: 01/01/2005

Ending: 12/31/2005

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 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

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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 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.)

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 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				8,356		8,356	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$ 8,356		\$ 8,356	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.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (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	\$ 5,693	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 5,000)	553,833		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,862		6
7	Other Prepaid Expenses	9,736		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Donations Receivable</u>	882,553		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,480,677	\$	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	12,462,619		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,447,676		16
17	Accumulated Depreciation (book methods)	(8,585,365)		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)	\$ 6,965,930	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,446,607	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 206,863	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,751		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	15,431		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)	\$ 279,045	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000		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)	\$ 600,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 879,045	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,567,562	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,446,607	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,117,135	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,117,135	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(549,573)	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)	\$ (549,573)	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)	\$ 7,567,562	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Little Sisters of the Poor# 0025346Report Period Beginning: 01/01/2005Ending: 12/31/2005**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	\$ 2,974,460	1
2	Discounts and Allowances for all Levels	(82,649)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,891,811	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	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		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	2,249,251	24
25	Interest and Other Investment Income***	1,294	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,250,545	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees (Adjusted Out on Sch V)	18,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,160,356	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,921,519	31
32	Health Care	1,934,888	32
33	General Administration	1,283,454	33
B. Capital Expense			
34	Ownership	520,102	34
C. Ancillary Expense			
35	Special Cost Centers	8,356	35
36	Provider Participation Fee	41,610	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,709,929	40
41	Income before Income Taxes (line 30 minus line 40)**	(549,573)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (549,573)	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: 01/01/2005

Ending:

12/31/2005

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
2	Assistant Director of Nursing				2
3	Registered Nurses	17,216	452,399	24.08	3
4	Licensed Practical Nurses	3,810	109,018	23.97	4
5	CNAs & Orderlies	59,032	874,194	12.84	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,824	33,642	15.51	9
10	Activity Assistants	3,385	35,317	9.54	10
11	Social Service Workers	1,258	27,074	20.73	11
12	Dietician				12
13	Food Service Supervisor	1,981	35,789	15.98	13
14	Head Cook				14
15	Cook Helpers/Assistants	32,131	344,785	9.33	15
16	Dishwashers				16
17	Maintenance Workers	8,105	175,490	18.51	17
18	Housekeepers	22,002	266,069	10.40	18
19	Laundry	10,379	98,741	8.55	19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	13,753	221,736	14.77	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	1,928	26,257	12.55	31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	176,804	2,700,511 *	\$ 13.40	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	133	\$ 4,655	1-3	35
36	Medical Director	60	3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	2,940	10-3	39
40	Physical Therapy Consultant	61	3,538	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	57	10A-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Stipend for One</u>				46
47	<u>Sister Acting as Director of</u>				47
48	<u>Nursing at \$750 For 12 Months</u>	2,080	9,000	10-3	48
49	TOTAL (lines 35 - 48)	2,433	\$ 23,190		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	17	861	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	17	\$ 861		53

Facility Name & ID Number Little Sisters of the Poor

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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	\$ 43,203	IDPH License Fee	\$		
				Unemployment Compensation Insurance	10,086	Advertising: Employee Recruitment	4,703		
				FICA Taxes	206,589	Health Care Worker Background Check			
				Employee Health Insurance	353,169	(Indicate # of checks performed <u>19</u>)	380		
				Employee Meals		Public Relations	27,757		
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	1,748		
				Retirement Plan	62,790	Licenses and Fees	3,081		
				Employee Physicals	248	Dues - Life Services Network of IL	3,818		
						Dues - Buying Service	1,302		
						Dues - Misc	485		
						Less: Public Relations Expense	(27,757)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description				Amount					
Stipend for Two Sisters Acting as Administrator and Assistant Administrator at \$750 For 12 Months Per Sister				\$ 18,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 18,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Taxl	Unemploy Comp Consult	\$ 393					Out-of-State Travel	\$	
ADP	Payroll Processing	12,055							
Varey & Vaccariello CPAs PC	Accounting and Auditing	31,300					In-State Travel		
Jackson Lewis	Legal (Care Related)	1,033							
							Seminar Expense		
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 44,781			TOTAL		\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Little Sisters of the Poor

Report Period Beginning: 01/01/2005 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	Repair to Heat Pump	10/2002	\$ 1,637	3 Yrs	\$ 15	\$ 546	\$ 546	\$ 530					
2	Repair to Lobby Heater	01/2003	3,870	3 Yrs		1,290	1,290	1,290					
3	Boiler Repair	03/2003	2,518	3 Yrs		699	839	839	141				
4	Condenser Pump	03/2003	1,438	3 Yrs		399	479	479	81				
5	Repair Water Pump	04/2003	2,529	3 Yrs		632	843	843	211				
6	Repair Exhaust Fans	05/2003	2,192	3 Yrs		487	731	731	243				
7	Repair Backflow Prev	03/2004	2,000	3 Yrs			556	667	667	110			
8	Repair Hot Water Valv	03/2004	2,701	3 Yrs			750	900	900	151			
9	Repair Heat Pump	05/2004	1,946	3 Yrs			432	649	649	216			
10	Repair Heat Pump	08/2004	1,771	3 Yrs			246	590	590	345			
11	Repair Kitchen HVAC	09/2004	2,290	3 Yrs			254	763	763	510			
12	Repair Kitchen HVAC	10/2004	1,499	3 Yrs			125	500	500	374			
13	Repair Water Heater	03/2005	3,349	3 Yrs				931	1,116	1,116	186		
14	Repair 2 Colling Towers	06/2005	1,960	3 Yrs				382	653	653	272		
15	Repair Chiller	09/2005	3,043	3 Yrs				338	1,014	1,014	677		
16													
17													
18													
19													
20	TOTALS		\$ 34,743		\$ 15	\$ 4,053	\$ 7,091	\$ 10,432	\$ 7,528	\$ 4,489	\$ 1,135	\$	\$

