

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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

HFS 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 01/01/2007 to 12/31/2007 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) Mother Margaret Patricia Lennon

(Title) President

(Signed) _____ (Date) _____

Paid Preparer (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: 01/01/2007 Ending: 12/31/2007

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 bedsN/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>713</u>			<u>713</u>	8
9	SNF/PED					9
10	ICF	<u>23,425</u>	<u>1,141</u>		<u>24,566</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,138</u>	<u>1,141</u>		<u>25,279</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.13%

D. How many bed-hold days during this year were paid by the Department?

56 (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 CareF. Does the facility maintain a daily midnight census? YESG. 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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	370,803	20,794	54,094	445,691		445,691		445,691		1
2	Food Purchase		197,587		197,587		197,587	(105,125)	92,462		2
3	Housekeeping	29,224	20,547	225,541	275,312		275,312		275,312		3
4	Laundry	88,406	12,012	36,565	136,983		136,983	(5,579)	131,404		4
5	Heat and Other Utilities			391,844	391,844		391,844	(107,436)	284,408		5
6	Maintenance	178,391	31,744	201,590	411,725		411,725	(84,615)	327,110		6
7	Other (specify):*			106,093	106,093		106,093		106,093		7
8	TOTAL General Services	666,824	282,684	1,015,727	1,965,235		1,965,235	(302,755)	1,662,480		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,581,758	77,678	190,529	1,849,965		1,849,965		1,849,965		10
10a	Therapy	57,999	299		58,298		58,298		58,298		10a
11	Activities	62,674	20,723	91,948	175,345		175,345		175,345		11
12	Social Services	51,259			51,259		51,259		51,259		12
13	CNA Training										13
14	Program Transportation			4,646	4,646		4,646		4,646		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,753,690	98,700	290,123	2,142,513		2,142,513		2,142,513		16
	C. General Administration										
17	Administrative			73,603	73,603		73,603		73,603		17
18	Directors Fees										18
19	Professional Services			63,728	63,728		63,728		63,728		19
20	Dues, Fees, Subscriptions & Promotions			34,329	34,329		34,329	(19,092)	15,237		20
21	Clerical & General Office Expenses	262,574	18,351	111,579	392,504		392,504	(18,000)	374,504		21
22	Employee Benefits & Payroll Taxes			584,312	584,312		584,312		584,312		22
23	Inservice Training & Education			3,499	3,499		3,499		3,499		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			13,937	13,937		13,937		13,937		25
26	Insurance-Prop.Liab.Malpractice			49,009	49,009		49,009	(6,307)	42,702		26
27	Other (specify):* Bad Debts			3,088	3,088		3,088	(3,088)			27
28	TOTAL General Administration	262,574	18,351	937,084	1,218,009		1,218,009	(46,487)	1,171,522		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,683,088	399,735	2,242,934	5,325,757		5,325,757	(349,242)	4,976,515		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: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			482,797	482,797	482,797	(36,074)	446,723			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			27,000	27,000	27,000	(27,000)				32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			509,797	509,797	509,797	(63,074)	446,723			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		8,874		8,874	8,874		8,874			39
40	Barber and Beauty Shops			20,084	20,084	20,084		20,084			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		8,874	61,694	70,568	70,568		70,568			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,683,088	408,609	2,814,425	5,906,122	5,906,122	(412,316)	5,493,806			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: 01/01/2007

Ending: 12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(105,125)	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	(5,579)	4		8
9	Non-Straightline Depreciation	(36,074)	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	(105,336)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	4,489	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(6,307)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,088)	27		24
25	Fund Raising, Advertising and Promotional	(19,092)	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	(89,104)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (385,316)		\$	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)	(27,000)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (27,000)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (412,316)		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

BHF USE ONLY					
48		49		50	51
					52

Little Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Line 15 - Non-Care Related Owner's Transactions	\$ (89,104)	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	(89,104)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(105,125)	0	0	0	0	0	0	0	0	0	0	(105,125)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,579)	0	0	0	0	0	0	0	0	0	0	(5,579)	4
5	Heat and Other Utilities	(107,436)	0	0	0	0	0	0	0	0	0	0	(107,436)	5
6	Maintenance	(84,615)	0	0	0	0	0	0	0	0	0	0	(84,615)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(302,755)	0	0	0	0	0	0	0	0	0	0	(302,755)	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	(19,092)	0	0	0	0	0	0	0	0	0	0	(19,092)	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	(6,307)	0	0	0	0	0	0	0	0	0	0	(6,307)	26
27	Other (specify):*	(3,088)	0	0	0	0	0	0	0	0	0	0	(3,088)	27
28	TOTAL General Administration	(46,487)	0	0	0	0	0	0	0	0	0	0	(46,487)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(349,242)	0	0	0	0	0	0	0	0	0	0	(349,242)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Sisters of the Poor

0025346

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(36,074)	0	0	0	0	0	0	0	0	0	0	(36,074)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(27,000)	0	0	0	0	0	0	0	0	0	(27,000)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(36,074)	(27,000)	0	(63,074)	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)	(385,316)	(27,000)	0	(412,316)	45								

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	19 Payroll Processing	\$ 24,486	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	\$ 24,486	\$
2	V	32 Interest Expense	27,000	Little Sisters of the Poor - Chicago Province, Inc.	0.00%		(27,000)
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 51,486			\$ 24,486	\$ * (27,000)

* 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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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

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		3	4	5	6		8	9	10						
		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						\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	LSP - Chicago Province, Inc.	X		Working Capital	NONE	12/13/04	300,000	300,000	12/13/09	0.0300	9,000						
7	LSP - Chicago Province, Inc.	X		Working Capital	NONE	05/05/05	300,000	300,000	05/05/10	0.0300	9,000						
8	LSP - Chicago Province, Inc.	X		Working Capital	NONE	02/03/06	300,000	300,000	02/03/11	0.0300	9,000						
9	TOTAL Facility Related						\$ 900,000	\$ 900,000			\$ 27,000						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 900,000	\$ 900,000			\$ 27,000						

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

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

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

Facility Name & ID Number Little Sisters of the Poor# 0025346 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 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 2007 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:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 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 2006 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 2006.

	(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Little Sisters of the Poor

0025346 Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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:

01/01/2007 Ending: 12/31/2007

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1980	1980	\$ 7,986,351	\$ 229,150	40	\$ 199,658	\$ (29,492)	\$ 5,516,223	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)	182,111	9
10		Sliding Gates, Misc Electric & Decorating		1982	9,877	283	40	247	(36)	6,299	10
11		Building Renovation		1983	10,031	288	40	251	(37)	6,161	11
12		Land Improvement - Landscaping		1983	3,265		20			3,265	12
13		Construction of Beauty Shop		1984	27,853	799	40	696	(103)	16,367	13
14		Kitchen Tile, Lighting, Ice Cream Parlor, Reception Area, Closets		1985	41,873	1,201	40	1,046	(155)	23,566	14
15		Land Improvement - Covered Walkway, Concrete Patios		1985	72,492		20			72,492	15
16		Land Improvement - Parking Lot Lights, Park Area		1986	12,805		20			12,805	16
17		New Garage		1986	40,590	1,165	40	1,015	(150)	21,858	17
18		Chapel Renovation		1988	66,715	1,914	40	1,668	(246)	32,533	18
19		Electric Work for New Garage		1989	7,615	219	40	191	(28)	3,533	19
20		Garage Completion, Repiping Storage Facility		1990	154,974	4,447	40	3,875	(572)	67,830	20
21		Land Improvement - Paving/Resurface Parking Lots		1990	27,860	1,599	20	1,393	(206)	24,386	21
22		Boiler Room Floor Drains		1991	6,413	184	40	160	(24)	2,640	22
23		Land Improvement - New sidewalks		1996	3,050	175	20	152	(23)	1,748	23
24		Senior Center, Physical Therapy & Elevator Renovation		1997	332,952	9,553	40	8,324	(1,229)	87,402	24
25		Walkway Renovation		1997	222,446	6,383	40	5,562	(821)	58,393	25
26		Combining of Rooms and Room Conversions		1997	37,098	1,064	40	927	(137)	9,734	26
27		Senior Center and Physical Therapy		1998	7,258	208	40	182	(26)	1,729	27
28		Kitchen Renovation		1999	711,148	20,404	40	17,779	(2,625)	151,121	28
29		Window Replacements		1999	239,657	6,876	40	5,991	(885)	50,924	29
30		2nd Floor Room Renovations		1999	162,707	4,670	40	4,069	(601)	34,581	30
31		Land Improvement - Brick Paving of Second Courtyard		2000	16,555	950	20	828	(122)	6,210	31
32		Window Replacements		2000	271,260	7,783	40	6,781	(1,002)	50,857	32
33		Auditorium Roof		2000	50,927	1,461	40	1,273	(188)	9,542	33
34		Two New Electric Front Doors		2001	2,645	76	40	66	(10)	429	34
35		Land Improvement - Concrete Walk and Base		2001	2,527	145	20	126	(19)	819	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:

01/01/2007 Ending: 12/31/2007

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)	\$ 66	37
38	Kitchen Main Grease Trap Replacement	2002	10,443	300	40	261	(39)	1,436	38
39	Roof Replacements	2002	25,966	745	40	649	(96)	3,570	39
40	Land Improvement - Parking Lot Lights, EE Parking Lot	2003	18,123	1,040	20	906	(134)	4,077	40
41									41
42									42
43									43
44	Capital Building Repair - Per P/A Desk Audit	1985	41,413		40	1,035	1,035	23,815	44
45	CBR - Tuckpointing, Repair Work, Sewer & Doors	1998	131,347		20	6,567	6,567	62,387	45
46	CBR - Flooring, Elec, Plumbing, Kitchen Rprs & Seal Coating	2002	33,755		5	3,375	3,375	33,755	46
47	CBR - Auto, Windows, Fl, Boiler, K, SD & Plumb Rprs	2003	28,582		5	5,716	5,716	25,722	47
48	CBR - Various HVAC Repairs and Sidewalk Repairs	2004	20,124		5	4,025	4,025	14,087	48
49	CBR - Door Alarms and Fluid Cooler Basin	2005	7,322		5	1,464	1,464	3,660	49
50	CBR - Door, Elevator, Plumbing and Heat Pump Repairs	2007	77,636		10	3,882	3,882	3,882	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)		\$ 11,198,859	\$ 310,979		\$ 297,020	\$ (13,959)	\$ 6,632,015	70

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	01 Ford Taurus	2001	\$ 16,957	\$	\$	\$	4	\$ 16,957	76
77	Care Use	01 Ford F150 w/P1 & Spdr	2001	26,618				4	26,618	77
78	Care Use	03 Toyota Camry	2002	16,884				4	16,884	78
79	Care Use	03 Ford Allstar Van	2003	22,915	3,287	2,864	(423)	4	22,915	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: 01/01/2007 Ending: 12/31/2007

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	\$ 1,398,915	\$ 155,581	\$ 135,558	\$ (20,023)	10 Years	\$ 1,083,374	71
72	Current Year Purchases	9,606	702	611	(91)	10 Years	611	72
73	Fully Depreciated Assets	458,394				10 Years	458,394	73
74								74
75	TOTALS	\$ 1,866,915	\$ 156,283	\$ 136,169	\$ (20,114)		\$ 1,542,379	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	04 Ford Truck Econoline	2003	\$ 19,384	\$ 2,781	\$ 2,422	\$ (359)	4	\$ 19,384	76
77	Care Use	06 Toyota Sienna	2006	17,487	5,018	4,372	(646)	4	6,558	77
78	Care Use	07 Ford E250 Van	2007	31,012	4,449	3,876	(573)	4	3,876	78
79										79
80	TOTALS			\$ 151,257	\$ 15,535	\$ 13,534	\$ (2,001)		\$ 113,192	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)	\$ 13,775,527	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 482,797	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 446,723	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (36,074)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,287,586	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	\$ 40,023	\$ 982,708	86
87	Equip - Convent Allocation Various	275,763	20,114	227,825	87
88	Vehicles - Convent Allocation Var	22,344	2,001	16,721	88
89					89
90					90
91	TOTALS	\$ 1,902,046	\$ 62,138	\$ 1,227,254	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.

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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>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>
--	---	--

*** ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING**

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	5 Units 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				8,874		8,874	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			\$		\$	\$ 8,874		\$ 8,874	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# 0025346Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(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	\$ 65,945	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	396,622		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	209,382		5
6	Prepaid Insurance	33,347		6
7	Other Prepaid Expenses	45,242		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Donations Receivable</u>	50,753		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 801,291	\$	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	2,316,279		16
17	Accumulated Depreciation (book methods)	(9,347,532)		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)	\$ 6,072,366	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,873,657	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 33,417	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,889		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,314		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	68,523		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)	\$ 169,143	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	900,000		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)	\$ 900,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,069,143	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,804,514	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,873,657	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,768,344	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,768,344	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(963,830)	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)	\$ (963,830)	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)	\$ 5,804,514	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Little Sisters of the Poor# 0025346Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 3,040,200	1
2	Discounts and Allowances for all Levels	(90,089)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,950,111	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	1,944,544	24
25	Interest and Other Investment Income***	28,637	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,973,181	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees (Adjusted Out on Sch V)	18,000	28
28a	Gain on disposition of fixed assets	1,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,942,292	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,965,235	31
32	Health Care	2,142,513	32
33	General Administration	1,218,009	33
B. Capital Expense			
34	Ownership	509,797	34
C. Ancillary Expense			
35	Special Cost Centers	28,958	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)*	\$ 5,906,122	40
41	Income before Income Taxes (line 30 minus line 40)**	(963,830)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (963,830)	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: 01/01/2007

Ending:

12/31/2007

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	15,535	17,081	435,035	25.47	3
4	Licensed Practical Nurses	5,608	6,350	143,365	22.58	4
5	CNAs & Orderlies	63,623	73,010	976,222	13.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,807	1,887	57,999	30.74	8
9	Activity Director	1,637	2,028	35,010	17.26	9
10	Activity Assistants	2,518	2,800	27,664	9.88	10
11	Social Service Workers	1,797	2,192	51,259	23.38	11
12	Dietician					12
13	Food Service Supervisor	2,081	2,438	41,254	16.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,675	33,266	329,549	9.91	15
16	Dishwashers					16
17	Maintenance Workers	7,688	8,936	178,391	19.96	17
18	Housekeepers	2,142	2,338	29,224	12.50	18
19	Laundry	7,326	8,589	88,406	10.29	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,677	16,171	262,574	16.24	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	1,946	2,099	27,136	12.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,060	179,185	\$ 2,683,088 *	\$ 14.97	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	134	\$ 5,340	1-3	35
36	Medical Director	60	3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	131	3,927	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>One Sister Acting</u>				46
47	<u>as Director of Nursing at Stipend +</u>				47
48	<u>Insurance + Room & Board</u>	2,080	37,509	10-3	48
49	TOTAL (lines 35 - 48)	2,405	\$ 49,776		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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Little Sisters of the Poor

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Repair Backflow Prev	03/2004	\$ 2,000	3 Yrs	\$ 556	\$ 667	\$ 667	\$ 110	\$	\$	\$	\$	\$
2	Repair Hot Water Valv	03/2004	2,701	3 Yrs	750	900	900	151					
3	Repair Heat Pump	05/2004	1,946	3 Yrs	432	649	649	216					
4	Repair Heat Pump	08/2004	1,771	3 Yrs	246	590	590	345					
5	Repair Kitchen HVAC	09/2004	2,290	3 Yrs	254	763	763	510					
6	Repair Kitchen HVAC	10/2004	1,499	3 Yrs	125	500	500	374					
7	Repair Water Heater	03/2005	3,349	3 Yrs		931	1,116	1,116	186				
8	Repair 2 Colling Towers	06/2005	1,960	3 Yrs		382	653	653	272				
9	Repair Chiller	09/2005	3,043	3 Yrs		338	1,014	1,014	677				
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 20,559		\$ 2,363	\$ 5,720	\$ 6,852	\$ 4,489	\$ 1,135	\$	\$	\$	\$

Facility Name & ID Number Little Sisters of the Poor

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. \$ 19,219 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 X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,610
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ -0- Has any meal income been offset against related costs? No Indicate the amount. \$ -0-
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 25% 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.