		FOR BHF USE					

LL1

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

2022
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2022)

I. IDPH License ID Number: 0025346

Facility Name: Little Sisters of the Poor

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2022 to 12/31/2022 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 Hogarty
(Title) President

Paid Preparer
(Signed) (Date)
(Print Name and Title) Chris Prystawsky, President
(Firm Name & Address) Prystawsky & Co CPAs LLC, PO Box 347, Gilberts, IL 60136
(Telephone) (847) 531-0691 Fax # ( )

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: 01/01/2022 Ending: 12/31/2022

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF	1,965		11,647		274	204		14,090	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,965		11,647		274	204		14,090	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 50.79%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 76

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2022 Fiscal Year: 12/31/2022

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	767,052	34,016	68,052	869,120		869,120	(142,982)	726,138			1
2	Food Purchase		248,147		248,147		248,147		248,147			2
3	Housekeeping	338,731	24,525	2,432	365,688		365,688		365,688			3
4	Laundry	93,747	14,480	4,232	112,459		112,459	(2,743)	109,716			4
5	Heat and Other Utilities			267,726	267,726		267,726	(103,556)	164,170			5
6	Maintenance	199,077	40,443	170,880	410,400		410,400		410,400			6
7	Other (specify):* Security Guards			84,577	84,577		84,577		84,577			7
8	**TOTAL General Services**	1,398,607	361,611	597,899	2,358,117		2,358,117	(249,281)	2,108,836			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	2,215,411	112,586	171,564	2,499,561		2,499,561		2,499,561			10
10a	Therapy	91,959		146,494	238,453		238,453		238,453			10a
11	Activities	168,252	57,061	65,635	290,948		290,948		290,948			11
12	Social Services	66,633			66,633		66,633		66,633			12
13	CNA Training											13
14	Program Transportation			4,526	4,526		4,526		4,526			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,542,255	169,647	391,219	3,103,121		3,103,121		3,103,121			16
	C. General Administration											
17	Administrative	103,970		44,520	148,490		148,490		148,490			17
18	Directors Fees											18
19	Professional Services			184,218	184,218		184,218		184,218			19
20	Dues, Fees, Subscriptions & Promotion			84,980	84,980		84,980	(57,349)	27,631			20
21	Clerical & General Office Expenses	555,485	40,906	533,380	1,129,771		1,129,771	(368,405)	761,366			21
22	Employee Benefits & Payroll Taxes			1,036,347	1,036,347		1,036,347		1,036,347			22
23	Inservice Training & Education			12,510	12,510		12,510		12,510			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			13,578	13,578		13,578		13,578			25
26	Insurance-Prop.Liab.Malpractice			57,125	57,125		57,125	(7,352)	49,773			26
27	Other (specify):*											27
28	**TOTAL General Administration**	659,455	40,906	1,966,658	2,667,019		2,667,019	(433,106)	2,233,913			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,600,317	572,164	2,955,776	8,128,257		8,128,257	(682,387)	7,445,870			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 reclassificatior

Facility Name & ID Number Little Sisters of the Poor #0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			340,544	340,544		340,544	(298,598)	41,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			340,544	340,544		340,544	(298,598)	41,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			10,304	10,304		10,304		10,304			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,111	164,111		164,111		164,111			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			174,415	174,415		174,415		174,415			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,600,317	572,164	3,470,735	8,643,216		8,643,216	(980,985)	7,662,231			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: 01/01/2022 Ending: 12/31/2022

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(142,982)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,184)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,743)	4		8
9	Non-Straightline Depreciation	(298,598)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(97,372)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,352)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(368,405)	21		24
25	Fund Raising, Advertising and Promotiona	(57,349)	20		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (980,985)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (980,985)		37

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

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

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

Little Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2022

Ending: 12/31/2022

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2022 **Ending:** 12/31/2022

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(142,982)	0	0	0	0	0	0	0	0	0	0	(142,982)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,743)	0	0	0	0	0	0	0	0	0	0	(2,743)	4
5	Heat and Other Utilities	(103,556)	0	0	0	0	0	0	0	0	0	0	(103,556)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(249,281)	0	0	0	0	0	0	0	0	0	0	(249,281)	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	(57,349)	0	0	0	0	0	0	0	0	0	0	(57,349)	20
21	Clerical & General Office Expenses	(368,405)	0	0	0	0	0	0	0	0	0	0	(368,405)	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	(7,352)	0	0	0	0	0	0	0	0	0	0	(7,352)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(433,106)	0	0	0	0	0	0	0	0	0	0	(433,106)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(682,387)	0	0	0	0	0	0	0	0	0	0	(682,387)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(298,598)	0	0	0	0	0	0	0	0	0	0	(298,598)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(298,598)	0	0	0	0	0	0	0	0	0	0	(298,598)	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)**	(980,985)	0	0	0	0	0	0	0	0	0	0	(980,985)	45

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LSP - St. Joseph's Home for the Elderly	Palatine, IL	Little Sisters of the Poor - Chicago Province, Inc	Palatine	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Corporate Compliance	$ 9,756	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	$ 9,756	$	1
2	V	19	Computer Consulting - IT	9,514	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	9,514		2
3	V	19	Payroll Processing	8,755	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	8,755		3
4	V	19	Human Resources	10,462	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	10,462		4
5	V	19	Windstream Internet	23,999	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	23,999		5
6	V	19	Spam Filter/Email Encription	1,227	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	1,227		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 63,713			$ 63,713	$ *	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: 01/01/2022 Ending: 12/31/2022

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Little Sisters of the Poor

ID# **0025346**

Report Period Beginning: **01/01/2022**

Ending: **12/31/2022**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Ownership Percentage	
1	Sister Margaret Charles Hogarty			Chicago	IL	0.00000	1
2	Sister Charles Patricia Mistretta			Chicago	IL	0.00000	2
3	Sister Ann Donnelly			Chicago	IL	0.00000	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							49
50							50

STATE OF ILLINOIS **Ownership Listing-2**

Little Sisters of the Poor

ID# **0025346**

Report Period Beginning: **01/01/2022**

Ending: **12/31/2022**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Ownership Percentage	
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							70
71							71
72							72
73							73
74							74
75							75
76							76
77							77
78							78
79							79
80							80
81							81
82							82
83							83
84							84
85							85
86							86
87							87
88							88
89							89
90							90
91							91
92							92
93							93
94							94
95							95
96							96
97							97
98							98
99							99
100							100

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City	Facility Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 2/31/2022

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	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	Various	5,100,000	5,100,000	Various	0.0300		7
8												8
9	TOTAL Facility Related						$ 5,100,000	$ 5,100,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,100,000	$ 5,100,000			$	15

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

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

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2021 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 2022 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		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2017		8
	2018		9
	2019		10
	2020		11
	2021		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2021	$	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.**

2021 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2021 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 2021.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2021 tax bills which were listed in Section A to this statement. Be sure to use the 2021 tax bill which is normally paid during 2022.

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 Numb Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 117,137 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

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

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

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

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

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

50 Apartments Independent Living Facility - 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 ca of the elderly poor. Expenses for the apartments are not included in this cost report

F. List the bed capacity for the building if it differs from the licensed tota _____

G. Have you properly capitalized all major repairs and equipment purchases Yes

H. Are you presently operating under a sale and leaseback arrangement' No

If YES, give effective date of lease _____

I. Are you presently operating under a sublease agreement' No

J. 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 ove _____

K. Does this cost report reflect any organization or pre-operating costs which are being amortized' [ ] YES [X] NO

If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1980	1980	$ 8,261,076	$	40	$	$	$ 8,261,076	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Improvements 7/1/1982 - 12/31/2015				2,209,746	59,848	40	52,145	(7,703)	1,330,732	10
11	Exterior Masonry Tuckpointing			2016	81,885	2,350	40	2,047	(303)	13,306	11
12	1st Floor Nursing Station			2018	5,919	170	40	148	(22)	666	12
13	Coffee Shop/Buffet Room Addition			2019	12,198	350	40	304	(46)	760	13
14	Silicone Coating for Roof			2019	38,337	1,100	40	958	(142)	3,354	14
15	Belden Street Wall Repair			2020	7,406	212	40	185	(27)	462	15
16	Parking Lot Repair			2020	2,962	170	20	149	(21)	371	16
17	Courtyard Concrete			2021	5,141	296	20	258	(38)	387	17
18	Pave, Coat & Stripe Front and Side Lot			2022	17,522	503	20	438	(65)	438	18
19	Exterior Granite and Masonry			2022	13,052	187	40	163	(24)	163	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

*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: 01/01/2022 Ending: 12/31/2022

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capital Building Repair - Per P/A Desk Audit	1985	$ 41,413	$ 1,035	40	$ 1,035	$	$ 38,305	37
38	CBR-Tuckpointing , Sewer & Door Repair	1998	131,347		20			131,347	38
39	CBR-Door Elevator, Plumbing & Heat Pump Repair	2007	77,636		10			77,636	39
40	CBR-Roof Repair, Exterior Brick, HVAC AC Repair	2008	110,671	5,534	20	5,534		80,253	40
41	CBR-Exterior Brick, Equip, Electrical & Condenser Repair	2009	31,512	1,576	20	1,576		21,276	41
42	CBR-Plumbing electrical & HVAC Repairs	2010	22,125	1,106	20	1,106		13,825	42
43	CBR-Plumbing Disposal HVAC & Nursing Call Repair	2011	17,736	887	20	887		10,200	43
44	CBR-Plumbing & HVAC Repair	2012	17,027	1,703	10	1,703		17,027	44
45	CBR-Elevator, HVAC, Plumbing & Electrical Repair	2013	22,592	1,130	20	1,130		10,735	45
46	CBR-Parking Lot HVAC & Plumbing Repair	2014	16,432	822	20	822		6,987	46
47	CBR-Electrical & Plumbing Repair	2015	5,486	272	20	272		2,041	47
48	CBR-HVAC Repairs	2016	11,611	580	20	580		2,770	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,160,832	$ 79,831		$ 71,440	$ (8,391)	$ 10,024,117	70

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,573,860	$ 238,532	$ 207,833	$ (30,699)		$ 2,304,657	71
72	Current Year Purchases	151,681	8,095	7,053	(1,042)		7,053	72
73	Fully Depreciated Assets							73
74	less convent allocation	(425,680)						74
75	TOTALS	$ 3,299,861	$ 246,627	$ 214,886	$ (31,741)		$ 2,311,710	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached Schedule			$ 201,525	$ 14,085	$ 12,272	$ (1,813)		$ 143,928	76
77										77
78										78
79										79
80	TOTALS			$ 201,525	$ 14,085	$ 12,272	$ (1,813)		$ 143,928	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)	$ 15,303,218	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 340,543	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 298,598	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,945)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 12,479,755	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	Building - Convent Allocation	$ 1,648,570	$ 79,831	$ 1,480,665	86
87	Equipment - Convent Allocation	425,680	31,741	341,463	87
88	Vehicles - Convent Allocation	25,936	1,813	21,260	88
89					89
90					90
91	TOTALS	$ 2,100,186	$ 113,385	$ 1,843,388	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: 01/01/2022 Ending: 12/31/2022

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

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

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

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

	Fiscal Year Ending	Annual Rent
12.	/2023	$
13.	/2024	$
14.	/2025	$

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.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A3	hrs	$	2,243	$ 67,283	$	2,243	$ 67,283	1
2	Licensed Speech and Language Development Therapist	10A3	hrs		126	7,841		126	7,841	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A3	hrs		2,642	71,370		2,642	71,370	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			10,304			10,304	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	5,011	$ 156,798	$	5,011	$ 156,798	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: 01/01/2022 Ending: 12/31/2022

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2022 (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	$ 420,717	$	1
2	Cash-Patient Deposits	35,211		2
3	Accounts & Short-Term Notes Receivable Patients (less allowance 253,316)	2,336,753		3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,662		6
7	Other Prepaid Expenses	48,691		7
8	Accounts Receivable (owners or related parties			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,867,034	$	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	12,592,924		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	3,725,541		16
17	Accumulated Depreciation (book methods	(14,323,143)		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)**	$ 2,636,322	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,503,356	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 202,871	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,211		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,307		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 361,389	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,100,000		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)**	$ 5,100,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,461,389	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 41,967	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,503,356	$	48

*(See instructions.)

Facility Name & ID Numbe Little Sisters of the Poor # 0025346 Report Period Beginning 01/01/2022 Ending: 12/31/2022

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,691,915)	1
2	Restatements (describe)		2
3	**Prior Period Adjustment**	2,357,278	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 665,363	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43	(1,963,957)	7
8	Aquisitions of Pooled Companie		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purpose		12
13	Dividends Paid or Other Distributions to Owner	( )	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe) **Forgiveness of Debt**	1,340,561	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (623,396)	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)**	$ 41,967	24 *

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

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,958,012	1
2	Discounts and Allowances for all Levels	(150,113)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,807,899	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	230,585	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 230,585	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	3,640,775	24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,640,775	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,679,259	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,358,117	31
32	Health Care	3,103,121	32
33	General Administration	2,667,019	33
	B. Capital Expense		
34	Ownership	340,544	34
	C. Ancillary Expense		
35	Special Cost Centers	10,304	35
36	Provider Participation Fee	164,111	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,643,216	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,963,957)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,963,957)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 414,070.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS		45
46	MMAI-Medicaid is the Primary Paye	2,260,127.00	46
47	MMAI-Medicare is the Primary Paye		47
48	Private Pay	58,234.00	48
49	Mediciare Part A	75,468.00	49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$ 2,807,899	56

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,718	2,006	$ 102,243	$ 50.97	1
2	Assistant Director of Nursing	1,831	2,127	93,917	44.15	2
3	Registered Nurses	10,644	11,313	462,674	40.90	3
4	Licensed Practical Nurses	11,352	12,896	461,755	35.81	4
5	CNAs & Orderlies	44,020	48,699	1,047,724	21.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,571	4,207	91,959	21.86	8
9	Activity Director	1,926	2,138	50,516	23.63	9
10	Activity Assistants	4,681	5,637	117,736	20.89	10
11	Social Service Workers	2,014	2,110	66,633	31.58	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,113	62,874	29.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,790	36,594	704,178	19.24	15
16	Dishwashers					16
17	Maintenance Workers	6,094	7,058	199,077	28.21	17
18	Housekeepers	16,207	17,981	338,731	18.84	18
19	Laundry	5,138	5,486	93,747	17.09	19
20	Administrator	1,928	2,048	103,970	50.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,242	17,972	555,485	30.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,007	2,135	47,098	22.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,056	182,520	$ 4,600,317 *	$ 25.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	280	$ 15,837	1-3	35
36	Medical Director	40	3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) One Sister Acting				46
47	as Administrator at Stipend +				47
48	Insurance + Room & Board	2,080	44,520	17-3	48
49	TOTAL (lines 35 - 48)	2,400	$ 63,357		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,844	73,772	10-3	52
53	TOTAL (lines 50 - 52)	1,844	$ 73,772		53

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa V Wierzgac	Manager	0	$ 103,970
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,970

B. Administrative - Other

Description	Amount
Sister Acting as Administrator	$ 9,000
Stipend at $750/mo for 12 months	9,680
Health Insurance for 12 months	25,840
Room and Board for 12 months	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 44,520
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LSP - Chicago Province, Inc.	IT, HR, PR Corp Comp	$ 38,486
PKFMueller	Audit/Tax	49,800
Polaris Group	Consulting	2,100
Carlin & Associates	Consulting	1,600
ADP	Payroll Processing	19,881
Healthcare Resource Group	Medical Biller	31,596
Prystawsky & Co	Accounting	38,100
eProvider Solutions	Processing	2,655
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 184,218

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 114,563
Unemployment Compensation Insurance	15,913
FICA Taxes	339,376
Employee Health Insurance	413,106
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	3,632
Retirement Plan	144,499
Employee Physicals	4,437
Other	821
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,347

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,438
Health Care Worker Background Check	352
(Indicate # of checks performed 35)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	10,431
Subscriptions	8,614
License and Fees	2,511
Dues	1,295
Public Relations	57,349
Less: Public Relations Expense	(57,349)
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,631

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2022 Ending: 12/31/2022

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **No**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines belov
Use the drop down list to identify the associatior

Association Name	Amount
LEADING AGE	**5,408**
Other, please specify IL Aging Services	**5,023**
	10,431 **Total**

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATION
OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE	
Other, please specify IL Aging Services	
	Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVI
(2 and 3 combined)

LEADING AGE	**5,408**
Other, please specify IL Aging Services	**5,023**
	10,431 **Total**

(5) Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V. $ **19,215** Line **10**

(6) Have all costs reported on this form been determined using accounting procedure
consistent with prior reports? **Yes** If NO, attach a complete explanation

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmei
during this cost report period. $ **164,111**
This amount is to be recorded on line 42 of Schedule V

(8) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **No** If YES, attach an explanation of the allocatior

(9) Have costs for all supplies and services which are of the type that can be billed t
the Department, in addition to the daily rate, been properly classifie
in the Ancillary Section of Schedule V **Yes**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ _____ Has any meal income been offset agains
related costs? **N/A** Indicate the amount $ _____

(12) 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 program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients **25**
d. Have vehicle usage logs been maintained **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing sucl transportation during this reporting period. $ _____

(13) Has an audit been performed by an independent certified public accounting firm **Yes**
Firm Name: **PKF Mueller**

(14) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

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

Little Sisters of the Poor of Chicago, Inc. - St. Mary's Home
Facility ID# 0025346
Report Period 01/01/2022 - 12/31/2022

V. - Cost Center Expenses - Page 3

Line 7 - Other

Column 1		$ -
Column 2		-
Column 3 - Security Guard Contract		84,577
Column 4 Total		**$ 84,577**

Line 23 - Inservice Training & Education

Detail Of Expenses:

Travel Costs for Seminars	$ -	
Seminar Registration Fees	12,510	
Total		**$ 12,510**

Line 25 - Other Admin. Staff Transportation

Detail Of Expenses:

Tolls & Parking & Misc.	$ 1,278	
Gas & Oil	5,735	
State & City Licenses	71	
Repairs & Maintenance (All items under $2,500)	6,494	
Total		**$ 13,578**

The main administrative use for the vehicles is picking up supplies and general business.

Little Sisters of the Poor of Chicago, Inc. - St. Mary's Home
Facility ID# 0025346
Report Period 01/01/2022 - 12/31/2022

VI. Adjustment Detail - Page 5

Part A, Line 15 - Convent Portion of Plant Operations - Maintenance

Portion allocated to convent based on percentage of convent footage to total square footage.

Square ft. convent	17,304	=	.1287
Total square ft.	134,441		

Plant Operation & Maintenance Costs:

Heat and Other Utilities	$	261,605	
Maintenance		410,400	
Security Guards		84,577	
Total		756,582	
Costs to be Allocated		756,582	
Allocation Factor	X	0.1287	
Allocated Cost	*To Line 5*	$	97,372
Total Adjustment		**$**	**97,372**

Part A, Line 21 - Property Insurance

Property Insurance Costs	$	57,124	
Allocation Factor	X	0.1287	
Total Adjustment		**$**	**7,352**

Little Sisters of the Poor of Chicago, Inc. - St. Mary's Home
Facility ID# 0025346
Report Period 01/01/2022 - 12/31/2022

XI. Ownership Costs - Pages 13 & 13A
D. Vehicle Depreciation

Description	Cost per Books	0.8713 Allocated Cost	2021 Report A/D	Allocated 2022 S/L	2022 Report A/D
01 Ford Taurus	19,462	16,957	16,957	-	16,957
01 Ford F150 w/Pl & Spdr	30,550	26,618	26,618	-	26,618
03 Ford Allstar Van	26,300	22,915	22,915	-	22,915
07 Ford E250 Van	35,593	31,012	31,012	-	31,012
10 Chevy 3500 Van	32,280	28,126	28,126	-	28,126
20 Chrysler Pacifica	31,309	27,280	3,410	6,820	10,230
21 Mazda 6	24,031	20,938	2,617	5,234	7,851
18 Chevy Malibu	2,000	1,743	-	218	218
SUBTOTALS	201,525	175,589	131,655	12,272	143,927