

		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

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

<p>I. IDPH Facility ID Number: <u>0026989</u></p> <p>Facility Name: <u>THE MCALLISTER NURSING HOME</u></p> <p>Address: <u>18300 LAVERGNE LANE</u> <u>TINLEY PARK</u> <u>60477</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>708-798-2272</u> Fax # <u>708-798-2220</u></p> <p>IDPA ID Number: <u>26989</u></p> <p>Date of Initial License for Current Owners: <u>JAN 1 1950</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>GERARD C SCHREMENTI</u> Telephone Number: <u>708 748-2808</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-1-2000</u> to <u>12-31-2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____ (Type or Print Name) <u>THERESA RUSSO</u> (Title) <u>PRESIDENT</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>GERARD C SCHREMENTI</u> (Firm Name & Address) <u>GERARD C SCHREMENTI</u> (Telephone) <u>708-748-2808</u> Fax # <u>708-748-2820</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>THERESA RUSSO</u> (Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>GERARD C SCHREMENTI</u> (Firm Name & Address) <u>GERARD C SCHREMENTI</u> (Telephone) <u>708-748-2808</u> Fax # <u>708-748-2820</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
	<input checked="" type="checkbox"/> "Sub-S" Corp.																												
	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>THERESA RUSSO</u> (Title) <u>PRESIDENT</u>																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>GERARD C SCHREMENTI</u> (Firm Name & Address) <u>GERARD C SCHREMENTI</u> (Telephone) <u>708-748-2808</u> Fax # <u>708-748-2820</u>																												

Print Preview

Facility Name & ID Number **THE MCALLISTER NURSING HOME**

0026989 Report Period Beginning: **1-1-2000** Ending: **12-31-2000**

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 12/22/99

	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	69	Skilled (SNF)	69	21,635	1
2		Skilled Pediatric (SNF/PED)			2
3	42	Intermediate (ICF)	42	15,330	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	36,965	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Public Aid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	6,238	423	736	7,397	8
9	SNF/PED					9
10	ICF	12,949	7,515		20,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,187	7,938	736	27,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

D. How many bed-hold days during this year were paid by Public Aid? _____ (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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/51

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 10 and days of care provided 365

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 1-1-2000 Ending: 12-31-2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	150,022	12,225		162,247		162,247	0	162,247		1
2	Food Purchase		173,634		173,634	(22,995)	150,639	(1,114)	149,525		2
3	Housekeeping	143,027			143,027		143,027	0	143,027		3
4	Laundry	86,505	14,797		101,302		101,302	0	101,302		4
5	Heat and Other Utilities			98,662	98,662		98,662	0	98,662		5
6	Maintenance	38,964	21,755	74,128	134,847		134,847	0	134,847		6
7	Other (specify):*							0			7
8	TOTAL General Services	418,518	222,411	172,790	813,719	(22,995)	790,724	(1,114)	789,610		8
	B. Health Care and Programs										
9	Medical Director							0			9
10	Nursing and Medical Records	657,805	29,029	11,501	698,335		698,335	0	698,335		10
10a	Therapy							0			10a
11	Activities	68,077	6,003	4,549	78,629		78,629	0	78,629		11
12	Social Services	44,385			44,385		44,385	0	44,385		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	770,267	35,032	16,050	821,349		821,349		821,349		16
	C. General Administration										
17	Administrative	89,900			89,900		89,900	0	89,900		17
18	Directors Fees							0			18
19	Professional Services			81,337	81,337		81,337	7,189	88,526		19
20	Dues, Fees, Subscriptions & Promotions			13,544	13,544		13,544		13,544		20
21	Clerical & General Office Expenses	62,678	52,481	72,736	187,895		187,895	(1,818)	186,077		21
22	Employee Benefits & Payroll Taxes			238,376	238,376	22,995	261,371	0	261,371		22
23	Inservice Training & Education			1,352	1,352		1,352	0	1,352		23
24	Travel and Seminar							0			24
25	Other Admin. Staff Transportation		24,236		24,236		24,236	(12,665)	11,571		25
26	Insurance-Prop.Liab.Malpractice			55,446	55,446		55,446	0	55,446		26
27	Other (specify):*							0			27
28	TOTAL General Administration	152,578	76,717	462,791	692,086	22,995	715,081	(7,294)	707,787		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,341,363	334,160	651,631	2,327,154		2,327,154	(8,408)	2,318,746		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

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 1-1-2000 Ending: 12-31-2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			64,687	64,687		64,687	89,691	154,378			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			27,489	27,489		27,489	189,017	216,506			32
33	Real Estate Taxes			148,967	148,967		148,967	0	148,967			33
34	Rent-Facility & Grounds			227,278	227,278		227,278	(227,278)				34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			468,421	468,421		468,421	51,430	519,851			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers			23,881	23,881		23,881	0	23,881			39
40	Barber and Beauty Shops			1,621	1,621		1,621	0	1,621			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			61,106	61,106		61,106	0	61,106			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			86,608	86,608		86,608		86,608			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,341,363	334,160	1,206,660	2,882,183	0	2,882,183	43,022	2,925,205			45

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

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **THE MCALLISTER NURSING HOME** # **0026989** STATE OF ILLINOIS Report Period Beginning: **1-1-2000** Page 5 Ending: **12-31-2000**
 VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	22,162	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	(1,114)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(12,665)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,818)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule non care depreciation	(980)	30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 5,585		\$	30

OHF USE ONLY						
48		49	50	51	52	

Print Preview

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)	37,437		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,437		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 43,022		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.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 1-1-2000 Ending: 12-31-2000
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A													SUMMARY TOTALS (to Sch V, col.7)	
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		
A. General Services														
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,114)	0	0	0	0	0	0	0	0	0	0	(1,114)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,114)	0	0	0	0	0	0	0	0	0	0	(1,114)	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,189	0	0	0	0	0	0	0	0	0	7,189	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,818)	0	0	0	0	0	0	0	0	0	0	(1,818)	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	(12,665)	0	0	0	0	0	0	0	0	0	0	(12,665)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,483)	7,189	0	(7,294)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,597)	7,189	0	(8,408)	29								

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 1-1-2000 Ending: 12-31-2000

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

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	22,162	68,509	0	0	0	0	0	0	0	0	0	90,671	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	189,017	0	0	0	0	0	0	0	0	0	189,017	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(227,278)	0	0	0	0	0	0	0	0	0	(227,278)	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	22,162	30,248	0	0	0	0	0	0	0	0	0	52,410	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)	6,565	37,437	0	0	0	0	0	0	0	0	0	44,002	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number

THE MCALLISTER NURSING HOME

#

0026989

Report Period Beginning:

1-1-2000

Ending:

12-31-2000

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	TERESA RUSSO	PRESIDENT	ADM	35.00		40	100.00		\$ 49,300	17	1
2	ANGELINE OLIVOTTO	SECRETARY	BOOKEEPING	33.00		40	100.00		34,678	21	2
3	GERALDINE WAGNER	DIRECTOR	ASS'T ADM	16.00		40	100.00		40,600	17	3
4	DEENA RUSH	DIRECTOR	WARD CLERK	16.00		40	100.00		39,200	12	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,778		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.

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989 Report Period Beginning: 1-1-2000

Ending: 2-31-2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

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 _____
 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

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989

Report Period Beginning:

1-1-2000

Ending:

12-31-2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	AMERICAN NATIONAL		X	MORTGAGE	\$18,610.00	05-01-98	\$ 1,925,431	\$ 0		8.5	\$ 73,487	1								
2	PULLMAN BANK		X	MORGAGE	\$22,371.00	06-16-00	2,400,000	2,381,303	06-16-15	9.5	115,530	2								
3												3								
4												4								
5												5								
Working Capital																				
6	AMERICAN NATIONAL		X	WORKING CAPITAL		5-1-98	250,000	0		10	17,875	6								
7	PULLMAN BANK		X	WORKING CAPITAL			249,000	237,753		10	9,614	7								
8												8								
9	TOTAL Facility Related				\$40,981.00		\$ 4,824,431	\$ 2,619,056			\$ 216,506	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,824,431	\$ 2,619,056			\$ 216,506	15								

* 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.)

Print Preview

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	159,356	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.)	\$	155,097	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(4,259)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	153,226	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 used previously to calculate a payment rate. 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 19 _____ 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.	\$	148,967	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	155,605	8
	1996	154,151	9
	1997	150,453	10
	1998	203,957	11
	1999	147,799	12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	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.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,050 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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

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: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	care	217,800	1948	\$ 50,000	1
2					2
3	TOTALS	217,800		\$ 50,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989

Report Period Beginning:

1-1-2000 Ending: 12-31-2000

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	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1982	1982	\$ 97,585	\$	30	\$ 3,253	\$ 3,253	\$ 59,365	4
5	59	1977	1977	530,796	17,693	3	17,693		440,499	5
6	42	1955	1955	17,500	0	30			17,500	6
7	10	1999	1999	2,001,372	50,034	39	50,034		52,119	7
8		2000	2000	32,600	781	39	781		781	8
Improvement Type**										
9	IMPROVEMENTS			519,444	4,128	25	4,128		513,251	9
10	WINDOWS ROOF		84	48,985	979	30		(979)	48,985	10
11	PAINTING WALLPAPER		85	8,159	408	15	136	(272)	8,159	11
12	WATER HEATER		85	3,775		15			3,775	12
13	ROOF SIGNS WINDOW		88	13,042		20	652	652	8,251	13
14	ROOF WATER HTR FLOOR		89	25,565		10			25,565	14
15	REMODEL OFFICE		90	39,584	1,257	31	990	(267)	10,267	15
16	ROOF TILE AND CARPETING		90	7,696		10	385	385	7,695	16
17	DOORS STAIRWELL STORAGE		91	23,621		10	2,362	2,362	22,440	17
18	PARKING LOT AND FENCE		93	66,521	4,253	10	6,652	2,399	49,464	18
19	ACCESS RAMP		94	8,631	566	10	863	297	5,610	19
20	DINING ROOM		95	85,925	2,148	39	2,148		12,441	20
21	FENCE DOORS AND FLOOR		95	17,678	1,462	10	1,767	305	9,060	21
22	NURSES STATION		96	33,389	3,339	10	3,339			22
23	PLUMBING VENT STACKS AND DRAINS		97	12,400	1,309	10	1,240	(69)	4,805	23
24	KITCHEN DUCT AND CEILING		97	4,920	520	10	492	(28)	1,907	24
25	PARKING LOT		97	8,290	875	10	829	(46)	3,212	25
26	LAUNDRY IMPROVEMENTS		97	8,555	903	10	855	(48)	3,315	26
27	ARCHITECT		97	16,773	1,879	10	1,677	(202)	6,080	27
28	DOORS		97	1,259	143	5	252	109		28
29	ROOF AND DESK		97	15,730	1,887	10	1,573	(314)		29
30	LANDSCAPING		97	11,408	1,424	10	1,141	(283)	3,565	30
31	PAINT AND WALLPAPER		97	8,176	1,119	5	1,635	516	5,110	31
32	ROOF		2000	25,145	2,515	10	1,257	(1,258)	1,257	32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)			\$ 3694524	\$ 99,622		\$ 106,134	\$ 6,512	\$ 1,324,478	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.

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME # 0026989 Report Period Beginning: 1-1-2000 Ending: 12-31-2000

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	
37	Purchased in Prior Years	\$ 298,764	\$ 30,461	\$ 44,346	\$ 13,885		\$ 196,167	37
38	Current Year Purchases							38
39	Fully Depreciated Assets	295,480					295,480	39
40								40
41	TOTALS	\$ 594,244	\$ 30,461	\$ 44,346	\$ 13,885		\$ 491,647	41

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	
42	CARE	1995 GMC PICKUP	1995	\$ 22,276	\$ 2,133	\$ 3,898	\$ 1,765	5	\$ 22,275	42
43										43
44										44
45										45
46	TOTALS			\$ 22,276	\$ 2,133	\$ 3,898	\$ 1,765		\$ 22,275	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,361,044	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 132,216	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 154,378	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 22,162	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,838,400	51

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

	1 Description & Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
52	ice cream shoppe	\$ 25,000	\$ 625	\$ 3,568	52
53	cadillac		355		53
54					54
55					55
56					56
57	TOTALS	\$ 25,000	\$ 980	\$ 3,568	57

G. Construction-in-Progress

	Description	Cost	
58			58
59			59
60			60
61			61

* 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.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	05/01/55	42		\$ 227,278			3
4	Additions	05/01/57	59					4
5		12/22/99	10					5
6								6
7	TOTAL		111		\$ 227,278			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: _____ *

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

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.	/2001	\$ _____
13.	/2002	\$ _____
14.	/2003	\$ _____

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

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



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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989 Report Period Beginning:

1-1-2000 Ending: 12-31-2000

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

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

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

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989

Report Period Beginning: 1-1-2000

Ending:

12-31-2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-2000

(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	\$ (47,883)	\$	1
2	Cash-Patient Deposits	9,788		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	275,794		3
4	Supply Inventory (priced at)	2,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 239,699	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,126,515		15
16	Equipment, at Historical Cost	616,520		16
17	Accumulated Depreciation (book methods)	(1,467,245)		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)	\$ 275,790	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 515,489	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 257,359	\$	26
27	Officer's Accounts Payable	221,125		27
28	Accounts Payable-Patient Deposits	9,788		28
29	Short-Term Notes Payable	237,753		29
30	Accrued Salaries Payable	52,269		30
31	Accrued Taxes Payable (excluding real estate taxes)	56,192		31
32	Accrued Real Estate Taxes(Sch.IX-B)	153,226		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)	\$ 987,712	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	shareholder loan	23,672		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 23,672	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,011,384	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (495,895)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 515,489	\$	48

*(See instructions.)

Print Preview

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (215,441)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (215,441)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(280,454)	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)	\$ (280,454)	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)	\$ (495,895)	24 *

* This must agree with page 17, line 47.

Print Preview

Facility Name & ID Number THE MCALLISTER NURSING HOME

0026989

Report Period Beginning: 1-1-2000

Ending: 12-31-2000

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.

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,608,449	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,608,449	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 2,608,449	30

Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 813,719	31
32	Health Care	821,349	32
33	General Administration	692,086	33
B. Capital Expense			
34	Ownership	468,421	34
C. Ancillary Expense			
35	Special Cost Centers	25,502	35
36	Provider Participation Fee	61,106	36
D. Other Expenses (specify):			
37	Loss on sale of assets	6,720	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,888,903	40
41	Income before Income Taxes (line 30 minus line 40)**	(280,454)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (280,454)	43

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

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

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

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

Print Preview

	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	2,000	2,080	\$ 39,520	\$ 19.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,316	10,993	172,422	15.68	3
4	Licensed Practical Nurses	8,678	9,754	129,815	13.31	4
5	Nurse Aides & Orderlies	31,740	35,845	291,197	8.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,091	2,339	24,851	10.62	8
9	Activity Director	2,000	2,080	30,698	14.76	9
10	Activity Assistants	5,202	5,366	37,379	6.97	10
11	Social Service Workers	616	681	5,185	7.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,818	2,343	19,959	8.52	14
15	Cook Helpers/Assistants	15,585	17,424	130,063	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,080	38,964	18.73	17
18	Housekeepers	15,212	17,132	143,027	8.35	18
19	Laundry	10,416	11,928	86,505	7.25	19
20	Administrator	2,000	2,080	49,300	23.70	20
21	Assistant Administrator	2,000	2,080	40,600	19.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,428	6,669	62,678	9.40	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	2,000	2,080	39,200	18.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,102	132,954	\$ 1,341,363 *	\$ 10.09	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	\$ 4,180	10-3	35
36	Medical Director			36
37	Medical Records Consultant	2,416	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	3,560	10-3	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	184	10-3	44
45	Social Service Consultant	1,161	10-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 11,501		49

C. CONTRACT NURSES

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

Print Preview

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 FY1997	6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Print Preview

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS HEALTHCARE ASSOCIATION
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,000 Line 4
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 61,106
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO 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. \$ 22,995 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (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. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? _____
 - 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? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? _____
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview