

		FOR OHF USE					

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**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><b>I. IDPH Facility ID Number:</b> <u>0028985</u></p> <p>Facility Name: <u>MORTON TERRACE</u></p> <p>Address: <u>191 E. QUEENLAND</u> <u>MORTON</u> <u>61550</u>  <small>Number City Zip Code</small></p> <p>County: <u>TAZEWELL</u></p> <p>Telephone Number: <u>(309) 266-5331</u> Fax # <u>(309) 647-0500</u></p> <p>IDPA ID Number: <u>36-426478001</u></p> <p>Date of Initial License for Current Owners: <u>1/01/00</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><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>BOB KAGDA</u> Telephone Number: <u>( 847 ) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____ (Type or Print Name) <u>ROBERT KAPLAN</u></td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>BOB KAGDA/PARTNER</u> (Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>( 847 ) 675-3585</u> Fax <u>(847) 675-5777</u></td> </tr> </table> <p align="center">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>ROBERT KAPLAN</u>		(Title) _____		(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	Paid Preparer	(Print Name and Title) <u>BOB KAGDA/PARTNER</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1</u> (Telephone) <u>( 847 ) 675-3585</u> Fax <u>(847) 675-5777</u>
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Facility Name & ID Number MORTON TERRACE

# 0028985 Report Period Beginning: 01/01/2000 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 \_\_\_\_\_

	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	44	Skilled (SNF)	44	16,104	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,920	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	60,024	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	3,545	874	3,172	7,591	8
9	SNF/PED					9
10	ICF	39,691	9,794		49,485	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,236	10,668	3,172	57,076	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 95.09%)

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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  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 1/1/00

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/1/00 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 20 and days of care provided 3147

Medicare Intermediary ADMINISTAR FEDERAL

**IV. ACCOUNTING BASIS**

ACCURAL  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

Facility Name & ID Number **MORTON TERRACE** # **0028985** Report Period Beginning: **01/01/2000** 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
	<b>A. General Services</b>										
1	Dietary	238,451	21,834	9,677	269,962		269,962	0	269,962		1
2	Food Purchase		237,984		237,984		237,984	0	237,984		2
3	Housekeeping	175,925	94,127	0	270,052		270,052	0	270,052		3
4	Laundry	90,411	40,281	0	130,692		130,692	0	130,692		4
5	Heat and Other Utilities			125,129	125,129		125,129	0	125,129		5
6	Maintenance	90,212	38,515	38,662	167,389		167,389	0	167,389		6
7	Other (specify):*			10,297	10,297		10,297	0	10,297		7
8	<b>TOTAL General Services</b>	594,999	432,741	183,765	1,211,505		1,211,505		1,211,505		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,315	9,315		9,315	0	9,315		9
10	Nursing and Medical Records	2,080,700	155,848	119,750	2,356,298	4,836	2,361,134	0	2,361,134		10
10a	Therapy	131,014	1,212	1,214	133,440		133,440	0	133,440		10a
11	Activities	203,354	1,421	6,076	210,851		210,851	0	210,851		11
12	Social Services	46,142		637	46,779		46,779	0	46,779		12
13	Nurse Aide Training	30,575		0	30,575		30,575	0	30,575		13
14	Program Transportation			0				0			14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Progra</b>	2,491,785	158,481	136,992	2,787,258	4,836	2,792,094		2,792,094		16
	<b>C. General Administration</b>										
17	Administrative	60,747		215,000	275,747		275,747	(174,725)	101,022		17
18	Directors Fees			0				0			18
19	Professional Services			80,585	80,585	(4,836)	75,749	3,578	79,327		19
20	Dues, Fees, Subscriptions & Promotions			86,018	86,018		86,018	(24,761)	61,257		20
21	Clerical & General Office Expense	194,171	50,334	52,380	296,885		296,885	144,097	440,982		21
22	Employee Benefits & Payroll Taxes			381,026	381,026		381,026	0	381,026		22
23	Inservice Training & Education			4,946	4,946		4,946	0	4,946		23
24	Travel and Seminar			0				0			24
25	Other Admin. Staff Transportation			13,244	13,244		13,244	3,744	16,988		25
26	Insurance-Prop.Liab.Malpractice			98,807	98,807		98,807	0	98,807		26
27	Other (specify):*			0				17,926	17,926		27
28	<b>TOTAL General Administration</b>	254,918	50,334	932,006	1,237,258	(4,836)	1,232,422	(30,141)	1,202,281		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,341,702	641,556	1,252,763	5,236,021		5,236,021	(30,141)	5,205,880		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.

**IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			2,623	2,623		2,623	184,982	187,605		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			4,100	4,100		4,100	202,685	206,785		32
33	Real Estate Taxes			64,751	64,751		64,751	0	64,751		33
34	Rent-Facility & Grounds			454,180	454,180		454,180	(454,180)			34
35	Rent-Equipment & Vehicles			11,623	11,623		11,623	5,749	17,372		35
36	Other (specify):*							6,465	6,465		36
37	<b>TOTAL Ownership</b>			537,277	537,277		537,277	(54,299)	482,978		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		86,158	128,536	214,694		214,694	0	214,694		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			90,036	90,036		90,036	0	90,036		42
43	Other (specify):*							0			43
44	<b>TOTAL Special Cost Centers</b>		86,158	218,572	304,730		304,730		304,730		44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,341,702	727,714	2,008,612	6,078,028	0	6,078,028	(84,440)	5,993,588		45

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

Print Preview

**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 **MORTON TERRACE**

# **0028985**

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

**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 Program:				3
4 Non-Patient Meals		2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space		34		6
7 Sale of Supplies to Non-Patients		10		7
8 Laundry for Non-Patients		4		8
9 Non-Straightline Depreciation	(1,576)	30		9
10 Interest and Other Investment Income	(30)	32		10
11 Discounts, Allowances, Rebates & Refunds		2		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax		2		13
14 Non-Care Related Interest	0	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)		25		16
17 Non-Care Related Fees	0	20		17
18 Fines and Penalties		21		18
19 Entertainment	0	20		19
20 Contributions	(6,500)	20		20
21 Owner or Key-Man Insurance	0	22		21
22 Special Legal Fees & Legal Retainers		19		22
23 Malpractice Insurance for Individuals		26		23
24 Bad Debt	0	27		24
25 Fund Raising, Advertising and Promotional	(18,261)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees		13		27
28 Yellow Page Advertising	0	20		28
29 Other-Attach Schedule DEFERRED MAINT XIX-H		0	6	29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,367)		\$	30

OHF USE ONLY							
48		49		50		51	
							52

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

	1	2	3	4
	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)	(58,073)	SCHED		34
35 Other- Attach Schedule	0	TACHED		35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (58,073)			36
(sum of SUBTOTALS)				
37 TOTAL ADJUSTMENTS (A) and (B)	\$ (84,440)			37

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

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

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

Print Preview





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

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb MORTON TERRACE

# 0028985 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

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

Print Summary  
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 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	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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0 8
<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Program</b>	0	0	0	0	0	0	0	0	0	0	0	0 16
<b>C. General Administration</b>													
17	Administrative	0	0	(174,725)	0	0	0	0	0	0	0	0	(174,725) 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	3,578	0	0	0	0	0	0	0	0	3,578 19
20	Fees, Subscriptions & Promotions	(24,761)	0	0	0	0	0	0	0	0	0	0	(24,761) 20
21	Clerical & General Office Expenses	0	0	144,097	0	0	0	0	0	0	0	0	144,097 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	3,744	0	0	0	0	0	0	0	0	3,744 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	0	0	17,926	0	0	0	0	0	0	0	0	17,926 27
28	<b>TOTAL General Administration</b>	(24,761)	0	(5,380)	0	0	0	0	0	0	0	0	(30,141) 28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(24,761)	0	(5,380)	0	0	0	0	0	0	0	0	(30,141) 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 Numbr MORTON TERRACE

# 0028985

Report Period Beginning:

01/01/2000 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
D. Ownership		5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,576)	183,476	3,082	0	0	0	0	0	0	0	0	184,982	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	202,715	0	0	0	0	0	0	0	0	0	202,685	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(454,180)	0	0	0	0	0	0	0	0	0	(454,180)	34
35	Rent-Equipment & Vehicles	0	0	5,749	0	0	0	0	0	0	0	0	5,749	35
36	Other (specify):*	0	6,465	0	0	0	0	0	0	0	0	0	6,465	36
37	<b>TOTAL Ownership</b>	<b>(1,606)</b>	<b>(61,524)</b>	<b>8,831</b>	<b>0</b>	<b>(54,299)</b>	<b>37</b>							
<b>Ancillary Expense</b>														
<b>E. Special Cost Centers</b>														
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	<b>TOTAL Special Cost Cent</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
<b>GRAND TOTAL COST</b>														
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(26,367)</b>	<b>(61,524)</b>	<b>3,451</b>	<b>0</b>	<b>(84,440)</b>	<b>45</b>							

**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.



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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 215,000			\$	(215,000)
16	V	17 OFFICER SALARIES		FAMILY CARE MANAGEMENT	100.00%	40,275	40,275
17	V	19 PROFESSIONAL FEES		FAMILY CARE MANAGEMENT	100.00%	3,578	3,578
18	V	21 CLERICAL		FAMILY CARE MANAGEMENT	100.00%	144,097	144,097
19	V	27 P/R TAXES, INSUR.		FAMILY CARE MANAGEMENT	100.00%	17,926	17,926
20	V	25 TRANSPORTATION		FAMILY CARE MANAGEMENT	100.00%	3,744	3,744
21	V	30 DEPRECIATION		FAMILY CARE MANAGEMENT	100.00%	3,082	3,082
22	V	35 EQUIP. LEASE/OFFICE RENT		FAMILY CARE MANAGEMENT	100.00%	5,749	5,749
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 215,000			\$ 218,451	\$ * 3,451

Sum\_6A

-215000  
40275  
3578  
144097  
17926  
3744  
3082  
5749

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

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 adjustments entered on this page will automatically transfer to the summary pages.

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

STATE OF ILLINOIS

Facility Name & ID Number MORTON TERRACE # 0028985 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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

Sum\_6B

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

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 adjustments entered on this page will automatically transfer to the summary pages.

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

STATE OF ILLINOIS

Facility Name & ID Number MORTON TERRACE # 0028985 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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

Sum\_6C

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

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 adjustments entered on this page will automatically transfer to the summary pages.

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

STATE OF ILLINOIS

Facility Name & ID Number MORTON TERRACE # 0028985 Report Period Beginn 01/01/2000 Ending: 12/31/2000

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.

Table with 8 columns: Schedule V Line, Cost Per General Ledger, Amount, Name of Related Organization, Percent of Ownership, Operating Cost of Related Organization, Adjustments for Related Organization Costs (7 minus 4), and a final column for line numbers 15-39.

Sum\_6D

- \* Total must agree with the amount recorded on line 34 of Schedule VI. 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 adjustments entered on this page will automatically transfer to the summary pages.

## 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	ARNOLD KAPLAN								\$		1	
2											2	
3	arnold kaplan's total allowable compensation for cost report from family care management is:\$135000						see attached	salary	40,275		17-8	3
4											4	
5											5	
6	ROBERT KAPLAN										6	
7											7	
8	robert kaplan's total allowable compensation for cost report from family care management is:\$133000						see attached	salary	39,678		21-8	8
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$ 79,953		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 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 REI

\*\* 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

| the name(s)  
PORTS.

Facility Name & ID Number **MORTON TERRACE**

# **0028985** Report Period Beginning: **01/01/2000**

Ending: **1/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization: MORTON TERRACE,LTD.  
 Street Address 6840 W. TOUHY  
 City / State / Zip Code NILES,IL 60714  
 Phone Number ( 847 )647-8994  
 Fax Number ( 847 )647-0500

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	30	DEPRECIATION	DIRECT	1	1	\$ 183,476	\$ 0	1	\$ 183,476	1
2	32	INTEREST	DIRECT	1	1	202,715	0	1	202,715	2
3	36	amort.-mort.costs/comp. soft.	DIRECT	1	1	6,465	0	1	6,465	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					\$ 392,656	\$		\$ 392,656	25

[Print Preview](#)

Facility Name & ID Number **MORTON TERRACE**

# **0028985** Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

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

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	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	17	OFFICER SALARIES	PER CENSUS DAY	191,317	4	\$ 135,000	\$ 135,000	57,076	\$ 40,275	1
2	19	PROFESSIONAL FEES	PER CENSUS DAY	191,317	4	11,995		57,076	3,578	2
3	21	CLERICAL	PER CENSUS DAY	191,317	4	483,009	474,553	57,076	144,097	3
4	25	P/R TAXES, INSUR.	PER CENSUS DAY	191,317	4	60,086		57,076	17,926	4
5	30	TRANSPORTATION	PER CENSUS DAY	191,317	4	12,551		57,076	3,744	5
6	35	DEPRECIATION	PER CENSUS DAY	191,317	4	10,330		57,076	3,082	6
7	30	EQUIP. LEASE/OFFICE RE	PER CENSUS DAY	191,317	4	19,270		57,076	5,749	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					\$ 732,241	\$ 609,553		\$ 218,451	25

Facility Name & ID Number MORTON TERRACE

# 0028985 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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

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

Facility Name & ID Number MORTON TERRACE

# 0028985 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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

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

Facility Name & ID Number MORTON TERRACE

# 0028985 Report Period Beginning: 01/01/2000

Ending: 12/31/2000

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4	RELATED PARTY-										4							
5	MORTON TERRACE LTD	X	LASALLE NATIONAL BA	\$35,283.00	02/18/98	3,000,000	2,351,993		0.0729	182,540	5							
<b>Working Capital</b>																		
6	AMERICAN NATIONAL		X	WORKING CAPITAL						4,100	6							
7											7							
8	REL PARTY-MORT. TERR,LTD	X	LASALLE NATIONAL BA	INTEREST	07/02/97	400,000	389,386	REVOV	PRIME+	20,175	8							
9	TOTAL Facility Related			\$35,283.00		\$ 3,400,000	\$ 2,741,379			\$ 206,815	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$ 3,400,000	\$ 2,741,379			\$ 206,815	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.)

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

**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 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.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	64,751	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		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. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	64,751	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	8	
	1996	9	
	1997	10	
	1998	11	
	1999	12	
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>			
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.</b>			
	<b>FOR OFF USE ONLY</b>		
	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 CALCULATIC \$	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**

Facility Name & ID Number: MORTON TERRACE

# 0028985 Report Period Beginning:

01/01/2000 Ending: 12/31/2000

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,948 B. General Construction Type: Exterior TYPE 2 A Frame STEEL & WOOD Number of Stories           

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

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

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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	related party			\$	1
2	NURSING HOME			275,000	2
3	TOTALS			\$ 275,000	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

# 0028985

Report Period Beginning:

01/01/200( Ending: 12/31/2000

Facility Name & ID Number MORTON TERRACE

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	ROOF			2000	6,984	138	27.5	138		138	9
10	WATER HEATER			2000	3,025	60	27.5	60		60	10
11	FLOORING			2000	1,195	171	10	60	(111)	60	11
12	CURTAINS			2000	5,019	717	10	251	(466)	251	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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 1,086		\$ 509	\$ (577)	\$ 509	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

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

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STATE OF ILLINOIS

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Facility Name & ID Numbe MORTON TERRACE

# 0028985

Report Period Beginning:

01/01/200( 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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	144				\$ 2,304,979	\$	31.5	\$ 73,174	\$ 73,174	\$ 602,709	4
5	10		1994		664,515		39	17,039	17,039	110,055	5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	FLOORING		1984		1,269		10	0		1,269	9
10	DRIVEWAY		1986		3,050		15	203	203	2,944	10
11	FLOORING		1986		1,971		10	0		1,971	11
12	BLACKTOP		1986		9,150		15	498	498	9,150	12
13	IMPROVEMENTS		1987		24,402		20	1,220	1,220	16,165	13
14	ROOF, PREVENTION FIRE		1989		35,715		31.5	1,134	1,134	12,700	14
15	CABINETS		1991		7,930		31.5	253	253	2,395	15
16	FLOORING , CUBICLE TRACKS,SEWER WORK		1992		12,840		31.5	408	408	3,594	16
17	PLUMBING WATER PIPE		1995		35,685		39	915	915	5,300	17
18	FLOOR COVERING		1995		19,532		39	501	501	2,777	18
19	HAND RAILS		1995		15,014		39	385	385	2,037	19
20	PLUMBING		1996		10,000		39	256	256	1,227	20
21	HEATING		1996		5,900		39	151	151	711	21
22	WALK IN FREEZER		1996		11,000		39	282	282	1,210	22
23	DINING ROOM & PHYSICAL THERAPY ROOM ADDITION		1996		459,404		39	11,780	11,780	47,612	23
24	PLUMBING WORK		1997		7,344		39	188	188	666	24
25	ROOF TOP HEATING & COOLING UNITS		1997		14,273		39	366	366	1,296	25
26	ROOF REPAIR		1997		22,866		39	586	586	2,076	26
27	FIRE DOORS		1997		21,083		39	541	541	1,915	27
28	SMOKE PARTITION WALL / FIRE WALL IN ATTIC		1997		12,000		39	308	308	1,091	28
29	ADDITIONAL DINING ROOM WORK		1997		14,000		39	359	359	1,271	29
30	KITCHEN TILING		1998		4,218		39	108	108	311	30
31	FIRE SHUTTERS		1998		5,538		39	142	142	408	31
32	BUILT IN KITCHEN CABINTRY		1998		11,330		39	291	291	764	32
33	ROOF REPAIR		1998		4,483		39	115	115	254	33
34	KITCHEN & LAUNDRY REMODELING		1999		49,836		39	1,278	1,278	1,970	34
35	ALARM SYSTEM		1999		2,023		39	52	52	80	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 112,533	\$ 112,533	\$ 835,928	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

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

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STATE OF ILLINOIS

# 0028985

Report Period Beginning:

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01/01/2000 Ending: 12/31/2000

Facility Name & ID Numbe MORTON TERRACE

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		ELECTRONIC CAMERA		1999	1,702		39	44	44	68	9
10		NURSE CALL SYSTEM		1999	2,936		39	75	75	116	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$ 119	\$ 119	\$ 184	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.

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

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Facility Name & ID Numbe **MORTON TERRACE**

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3</b>				\$ #VALUE!	\$		\$	\$	\$	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

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

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# 0028985

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

Facility Name & ID Numbe MORTON TERRACE

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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 MORTON TERRACE

# 0028985

Report Period Beginning: 01/01/2000 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	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$	\$	\$	\$		\$	37
38	Current Year Purchases	10,755	1,537	538	(999)	10 YRS	538	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	730,724	73,906	73,906		10 YRS	471,165	40
41	TOTALS	\$ 741,479	\$ 75,443	\$ 74,444	\$ (999)		\$ 471,703	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				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 76,529	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 187,605	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 111,076	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,308,324	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	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.

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**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	_____/2001	\$ _____
13.	_____/2002	\$ _____
14.	_____/2003	\$ _____

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: \$ **373** Description: **ECOLAB - DISH MACHINE**  
(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		<b>VAN</b>	\$ <b>720.00</b>	\$ <b>8,640</b>	17
18				<b>2,610</b>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>720.00</b>	\$ <b>11,250</b>	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.



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Facility Name & ID Number MORTON TERRACE # 0028985 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

**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><b>THE FACILITY HIRES ONLY TRAINED AIDES.</b></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.

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Facility Name & ID Number MORTON TERRACE# 0028985 Report Period Beginning: 01/01/2000 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	2	3	4				
1	Licensed Occupational Therapist		hrs	\$		\$ 19,341	\$		\$ 19,341	1
2	Licensed Speech and Language Development Therapist		hrs			11,859			11,859	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			97,336			97,336	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				81,646		81,646	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Medical Supplies						4,272		4,272	
	Other (specify): <b>Laboratory</b>						240		240	13
14	<b>TOTAL</b>			\$		\$ 128,536	\$ 86,158		\$ 214,694	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.

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Facility Name &amp; ID Number MORTON TERRACE

# 0028985

Report Period Beginning: 01/01/2000

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	2	
	Operating	After	
		Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (77,406)	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	822,189	3
4	Supply Inventory (priced at )		4
5	Short-Term Investments		5
6	Prepaid Insurance	61,467	6
7	Other Prepaid Expenses	2,875	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 809,125	10
<b>B. Long-Term Assets</b>			
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	10,009	15
16	Equipment, at Historical Cost	16,969	16
17	Accumulated Depreciation (book methods)	(2,623)	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): <b>DEPOSITS</b>		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 24,355	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 833,480	25

	1	2	
	Operating	After	
		Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 162,508	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	171,291	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,342	31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,751	32
33	Accrued Interest Payable	3,905	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
<b>Other Current Liabilities(specify):</b>			
36	<b>Due to Profit Sharing</b>	3,402	36
37	<b>Due to Morton Terrace, Ltd.</b>	359,566	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 805,765	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	200,000	39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43	<b>Shareholders' Loans</b>	110,000	43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 310,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,115,765	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (282,285)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 833,480	48

\*(See instructions.)

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Facility Name & ID Number MORTON TERRACE# 0028985Report Period Beginning 1/01/2000Ending: 12/31/2000

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(282,285)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (282,285)	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (282,285)	<b>24 *</b>

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

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Facility Name &amp; ID Number MORTON TERRACE

# 0028985

Report Period Beginning: 01/01/2000

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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,738,524	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,738,524	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,189	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 57,189	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income**	30	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30	26
<b>E. Other Revenue (specify):***</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DISCOUNTS</b>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,795,743	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	\$ 1,211,505	31
32	Health Care	2,787,258	32
33	General Administration	1,237,258	33
<b>B. Capital Expense</b>			
34	Ownership	537,277	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	214,694	35
36	Provider Participation Fee	90,036	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,078,028	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(282,285)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (282,285)	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

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

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,935	2,186	\$ 49,645	\$ 22.71	1
2	Assistant Director of Nursing	3,889	4,418	97,944	22.17	2
3	Registered Nurses	17,546	19,271	365,797	18.98	3
4	Licensed Practical Nurses	24,306	26,660	425,775	15.97	4
5	Nurse Aides & Orderlies	111,229	117,096	1,117,135	9.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			131,014		8
9	Activity Director	3,938	4,559	53,152	11.66	9
10	Activity Assistants	16,773	18,295	150,202	8.21	10
11	Social Service Workers	3,827	4,486	46,142	10.29	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,107	28,212	13.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,043	26,403	210,239	7.96	15
16	Dishwashers					16
17	Maintenance Workers	5,484	6,244	90,212	14.45	17
18	Housekeepers	21,033	22,929	175,925	7.67	18
19	Laundry	10,552	11,073	90,411	8.16	19
20	Administrator	2,009	2,187	60,747	27.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,003	16,971	194,171	11.44	24
25	Vocational Instruction					25
26	Academic Instruction	1,478	1,622	30,575	18.85	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	2,548	2,675	24,404	9.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	269,602	289,182	\$ 3,341,702 *	\$ 11.56	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	M \$ 9,677	1-3	35
36	Medical Director	O 9,315	9-3	36
37	Medical Records Consultant	N 1,105	10-3	37
38	Nurse Consultant	T 0	10-3	38
39	Pharmacist Consultant	H 1,848	10-3	39
40	Physical Therapy Consultant	L 0	10a-3	40
41	Occupational Therapy Consultant	Y 0	10a-3	41
42	Respiratory Therapy Consultant		0 10a-3	42
43	Speech Therapy Consultant	F 0	10a-3	43
44	Activity Consultant	E 6,076	11-3	44
45	Social Service Consultant	E 637	12-3	45
46	Other(specify)	S		46
47	Rehab Consultant		1,214 10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,872		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10-3	50
51	Licensed Practical Nurses		10-3	51
52	Nurse Aides	116,797	10-3	52
53	TOTAL (lines 50 - 52)	\$ 116,797		53

Print Preview



Facility Name & ID Num MORTON TERRACE

# 0028985

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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