

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0045047

Facility Name: THE MOORINGS HEALTH CENTER

Address: 761 OLD BARN LANE ARLINGTON HEIGHT 6005
 Number City Zip Code

County: COOK

Telephone Number: 847-364-2435 **Fax #** 847-956-4495

HFS ID Number: 36-2167832001

Date of Initial License for Current Owners: 10/1/2000

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: DAN CIROCK **Telephone Number:** 847-492-4871

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/01/2005 to 03/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>ROBERT E. LANDSMAN</u>	
	(Title) <u>VICE PRESIDENT OF FINANCE</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047 Report Period Beginning: 04/01/2005 Ending: 03/31/2006

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 12/20/2005

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>84</u>	<u>31,716</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>32</u>	Intermediate (ICF)	<u>32</u>	<u>11,680</u>	3
4		Intermediate/DD			4
5	<u>68</u>	Sheltered Care (SC)	<u>67</u>	<u>24,455</u>	5
6		ICF/DD 16 or Less			6
7	<u>188</u>	TOTALS	<u>183</u>	<u>67,851</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>16,923</u>	<u>2,759</u>	<u>19,682</u>	8
9	SNF/PED					9
10	ICF	<u>2,547</u>	<u>9,504</u>		<u>12,051</u>	10
11	ICF/DD					11
12	SC		<u>13,894</u>		<u>13,894</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,547</u>	<u>40,321</u>	<u>2,759</u>	<u>45,627</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.25%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

ADULT DAY CAREF. 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 10/1/2000

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/1/2000 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 88 and days of care provided 2,759Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 3/31/2006 Fiscal Year: 3/31/2006

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2005 Ending: 03/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,457,436	51,370	65,601	1,574,407		1,574,407	(913,156)	661,251			1
2	Food Purchase		1,164,422		1,164,422	(3,575)	1,160,847	(673,291)	487,556			2
3	Housekeeping	645,900	43,801	137,019	826,720		826,720	(562,170)	264,550			3
4	Laundry											4
5	Heat and Other Utilities			792,243	792,243		792,243	(538,725)	253,518			5
6	Maintenance	610,708	166,014	549,963	1,326,685		1,326,685	(971,725)	354,960			6
7	Other (specify):* PUBLIC SAFETY	265,436	5,899	48,787	320,122		320,122	(841,349)	(521,227)			7
8	TOTAL General Services	2,979,480	1,431,506	1,593,613	6,004,599	(3,575)	6,001,024	(4,500,416)	1,500,608			8
	B. Health Care and Programs											
9	Medical Director	81,168	1,746	45,100	128,014		128,014		128,014			9
10	Nursing and Medical Records	3,678,355	320,230	390,818	4,389,403	(144,618)	4,244,785		4,244,785			10
10a	Therapy	328,600	3,707	45,296	377,603		377,603		377,603			10a
11	Activities	327,558	18,809	77,164	423,531		423,531		423,531			11
12	Social Services	138,852	6,297	96,792	241,941	(101,766)	140,175		140,175			12
13	CNA Training	47,121	441	1,594	49,156		49,156		49,156			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,601,654	351,230	656,764	5,609,648	(246,384)	5,363,264		5,363,264			16
	C. General Administration											
17	Administrative	272,435	22,815	2,122,450	2,417,700	(398,536)	2,019,164	(1,305,020)	714,144			17
18	Directors Fees											18
19	Professional Services			52,505	52,505		52,505	(37,703)	14,802			19
20	Dues, Fees, Subscriptions & Promotions			70,823	70,823	398,536	469,359	(444,411)	24,948			20
21	Clerical & General Office Expenses	243,373	53,114	168,425	464,912		464,912	(353,992)	110,920			21
22	Employee Benefits & Payroll Taxes			2,349,190	2,349,190	3,575	2,352,765	(1,599,880)	752,885			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			17,679	17,679		17,679	(17,679)				25
26	Insurance-Prop.Liab.Malpractice			252,025	252,025		252,025	(171,377)	80,648			26
27	Other (specify):*	457,640	3,443	162,583	623,666		623,666	(235,221)	388,445			27
28	TOTAL General Administration	973,448	79,372	5,195,680	6,248,500	3,575	6,252,075	(4,165,283)	2,086,792			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,554,582	1,862,108	7,446,057	17,862,747	(246,384)	17,616,363	(8,665,699)	8,950,664			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number THE MOORINGS HEALTH CENTER #0045047 Report Period Beginning: 04/01/2005 Ending: 03/31/2006

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			2,041,391	2,041,391		2,041,391	(1,392,561)	648,830			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,118	49,118		49,118	(49,118)				32
33	Real Estate Taxes			38,434	38,434		38,434	(33,438)	4,996			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,128,943	2,128,943		2,128,943	(1,475,117)	653,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					144,618	144,618		144,618			39
40	Barber and Beauty Shops					101,766	101,766		101,766			40
41	Coffee and Gift Shops		1,676		1,676		1,676		1,676			41
42	Provider Participation Fee			75,000	75,000		75,000		75,000			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,676	75,000	76,676	246,384	323,060		323,060			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,554,582	1,863,784	9,650,000	20,068,366		20,068,366	(10,140,816)	9,927,550			45

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning: 04/01/2005

Ending: 03/31/2006

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	\$ (223,277)	27	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,944)	27		4
5	Telephone, TV & Radio in Resident Rooms	(37,852)	21		5
6	Rented Facility Space	(71,768)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(49,118)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(17,679)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(388,624)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,912)	20		28
29	Other-Attach Schedule	(9,328,642)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,140,816)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ #####		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		101,766	12	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		144,618	10	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)			\$ 246,384		47

BHF USE ONLY					
48		49		50	51
					52

STATE OF ILLINOIS
THE MOORINGS HEALTH CENTER

Report Period Beginning: 04/01/2005
 Ending: 03/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	retirement expense dietary	\$ (913,156)	1	1
2	retirement expense food	(673,291)	2	2
3	retirement expense housekeeping	(562,170)	3	3
4	retirement expense utilities	(538,725)	5	4
5	retirement expense maintenance	(902,146)	6	5
6	retirement expense public safety	(217,683)	7	6
7	retirement expense administration	(1,373,032)	17	7
8	retirement expense professional fees	(35,703)	19	8
9	retirement expense dues fees & subscriptions	(33,306)	20	9
10	retirement expense clerical	(316,140)	21	10
11	retirement side employee benefits	(1,599,880)	22	11
12	retirement side insurance	(171,377)	26	12
13	Adult day care & other retirement costs	(623,666)	7	13
14	retirement expense depreciation	(1,392,561)	30	14
15	retirement expense re taxes	(33,438)	33	15
16	deferred maintenance adj	2,189	6	16
17	Nurse Administrator salary add back	68,012	17	17
18	non allowable memberships & publications	(12,569)	20	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,328,642)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning:

04/01/2005

Ending:

03/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(913,156)	0	0	0	0	0	0	0	0	0	0	(913,156)	1
2	Food Purchase	(673,291)	0	0	0	0	0	0	0	0	0	0	(673,291)	2
3	Housekeeping	(562,170)	0	0	0	0	0	0	0	0	0	0	(562,170)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(538,725)	0	0	0	0	0	0	0	0	0	0	(538,725)	5
6	Maintenance	(971,725)	0	0	0	0	0	0	0	0	0	0	(971,725)	6
7	Other (specify):*	(841,349)	0	0	0	0	0	0	0	0	0	0	(841,349)	7
8	TOTAL General Services	(4,500,416)	0	0	0	0	0	0	0	0	0	0	(4,500,416)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(1,305,020)	0	0	0	0	0	0	0	0	0	0	(1,305,020)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37,703)	0	0	0	0	0	0	0	0	0	0	(37,703)	19
20	Fees, Subscriptions & Promotions	(444,411)	0	0	0	0	0	0	0	0	0	0	(444,411)	20
21	Clerical & General Office Expenses	(353,992)	0	0	0	0	0	0	0	0	0	0	(353,992)	21
22	Employee Benefits & Payroll Taxes	(1,599,880)	0	0	0	0	0	0	0	0	0	0	(1,599,880)	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	(17,679)	0	0	0	0	0	0	0	0	0	0	(17,679)	25
26	Insurance-Prop.Liab.Malpractice	(171,377)	0	0	0	0	0	0	0	0	0	0	(171,377)	26
27	Other (specify):*	(235,221)	0	0	0	0	0	0	0	0	0	0	(235,221)	27
28	TOTAL General Administration	(4,165,283)	0	0	0	0	0	0	0	0	0	0	(4,165,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,665,699)	0	0	0	0	0	0	0	0	0	0	(8,665,699)	29

STATE OF ILLINOIS

Facility Name & ID Number **THE MOORINGS HEALTH CENTER**

0045047

Report Period Beginning:

04/01/2005 Ending:

Summary B

03/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,392,561)	0	0	0	0	0	0	0	0	0	0	(1,392,561)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,118)	0	0	0	0	0	0	0	0	0	0	(49,118)	32
33	Real Estate Taxes	(33,438)	0	0	0	0	0	0	0	0	0	0	(33,438)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,475,117)	0	(1,475,117)	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)	(10,140,816)	0	(10,140,816)	45									

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning: 04/01/2005 Ending: 03/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		MCGAW CARE CENTER	EVANSTON	PRESBYTERIAN HO	EVANSTON	HOME HEALTH
		BALMORAL CARE CENTER	LAKE FOREST	PRESBYTERIAN HO	EVANSTON	HOSPICE
		JAMES C. KING HOME	EVANSTON			

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)
1	V	9 MEDICAL DIRECTOR	\$ 654,971	PRESBYTERIAN HOMES	100.00%	\$ 654,971	\$
2	V	17 INFORMATION SYSTEMS	119,297	PRESBYTERIAN HOMES	100.00%	119,297	
3	V	17 OVERHEAD ADMINISTRATION	2,811,704	PRESBYTERIAN HOMES	100.00%	2,811,704	
4	V	17 MARKETING	797,149	PRESBYTERIAN HOMES	100.00%	797,149	
5	V	17 ACCOUNTING SERVICES	439,806	PRESBYTERIAN HOMES	100.00%	439,806	
6	V	17 HUMAN SERVICES	200,911	PRESBYTERIAN HOMES	100.00%	200,911	
7	V	17 BOARD ADMINISTRATION	27,777	PRESBYTERIAN HOMES	100.00%	27,777	
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 5,051,615			\$ 5,051,615	\$ *

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2005 Ending: 03/31/2006

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning: 04/01/2005

Ending: 3/31/2006

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 PRESBYTERIAN HOMES
 Street Address 3200 GRANT STREET
 City / State / Zip Code EVANSTON, IL 60201
 Phone Number (847-492-4871
 Fax Number (847-570-3426

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	9	MEDICAL DIRECTOR	DIRECT COST	1	\$ 654,971	\$ 81,168		\$ 0	1
2	17	INFORMATION SYSTEMS	DIRECT COST	1	119,297	64,944		0	2
3	17	OVERHEAD ADMINISTRATIO	DIRECT COST	1	2,811,704	149,953		0	3
4	17	MARKETING	DIRECT COST	1	797,149	262,100		0	4
5	17	ACCOUNTING SERVICES	DIRECT COST	1	439,806	216,614		0	5
6	17	HUMAN SERVICES	DIRECT COST	1	200,911	114,584		0	6
7	17	BOARD ADMINISTRATION	DIRECT COST	1	27,777	12,253		0	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				\$ 5,051,615	\$ 901,616		\$	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	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	PRESBYTERIAN HOMES	X		IMPUTED INTEREST ON PURCHASE PRICE					\$ 49,118	1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related				\$	\$			\$ 49,118	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related				\$	\$				14										
15	TOTALS (line 9+line14)				\$	\$			\$ 49,118	15										

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 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.)		\$ 105,255	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 105,255	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 105,255	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	160,565	8
	2002	67,833	9
	2003	109,502	10
	2004	114,043	11
	2005	105,255	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE MOORINGS HEALTH CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045047

CONTACT PERSON REGARDING THIS REPORT DAN CIROCK

TELEPHONE 847-492-4871 FAX #: 847-570-3426

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-10-113-004-0000</u>	<u>ASSISTED LIVING & HEALTHCARE</u>	\$ <u>105,255.00</u>	\$ <u>105,255.00</u>
2. <u>08-10-113-003-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>71,985.00</u>	\$ _____
3. <u>08-10-113-002-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>352.00</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>177,592.00</u>	\$ <u>105,255.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047 Report Period Beginning:

04/01/2005 Ending:

03/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,857 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories TWO

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

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

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

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

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

The Moorings of Arlington Heights: Retirement center 294 units, square footage 325,616

All expenses related to the retirement center have been adjusted out based on 68% of the census residing in the retirement community.

All of the Adult Day Care costs have been adjusted out of the cost report.

Food service has been adjusted by 58% for retirement center.

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			<u>2000</u>	<u>\$ 756,190</u>	1
2					2
3	TOTALS			\$ 756,190	3

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning:

04/01/2005 Ending: 03/31/2006

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	183		2000	1994	\$ 8,656,752	\$ 249,178	35	\$ 249,178		\$ 1,371,399	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		JENSEN HALSTEAD ARCHITECTS		2001	2,796	280	10	280		1,540	9
10		PAYMENTS TO ADVOCATE		2002	10,724	306	35	306		1,377	10
11		FACILITIES MANAGEMENT		2002	16,844	1,684	10	1,684		7,578	11
12		DECORATING		2002	5,459	546	10	546		2,457	12
13		FLOORING		2002	5,011	501	10	501		2,255	13
14		CABLING, CAMERAS, SOUND SYSTEM		2002	16,165	1,616	10	1,616		7,272	14
15		POOL REPAIRS		2002	4,789	479	10	479		2,155	15
16		HEATING & VENTALATION		2002	13,303	1,330	10	1,330		5,985	16
17		CABINETS		2002	938	94	10	94		423	17
18		DOOR LOCKS		2002	705	71	10	71		319	18
19		SHELTERED CARE ARCHITECTS		2002	13,065	653	20	653		3,239	19
20		VILLA ARCHITECTS		2002	17,574	879	20	879		3,955	20
21		BUILDING SIDING		2002	150,792	7,540	20	7,540		33,930	21
22		ARCHITECTS STUDIES		2002	18,109	905	20	905		4,073	22
23		CABINETS		2002	448	22	20	22		99	23
24		FOOD SERVICE EQUIPMENT		2002	512	26	20	26		117	24
25		FACILITIES MANAGEMENT		2003	27,833	2,783	10	2,783		9,741	25
26		CABLING, CAMERAS, SOUND SYSTEM		2003	5,490	549	10	549		1,922	26
27		DECORATING		2003	20,475	2,048	10	2,048		7,168	27
28		FIRE ALARM SYSTEMN		2003	12,565	1,257	10	1,257		4,399	28
29		CABINETS		2003	36,787	1,839	20	1,839		6,437	29
30		ELECTRICAL WIRING		2003	42,505	2,125	20	2,125		7,438	30
31		HEATING & VENTALATION		2003	90,418	4,521	20	4,521		15,823	31
32		ARCHITECTS STUDIES		2003	52,552	2,628	20	2,628		9,198	32
33		ASBESTOS REMOVAL		2003	7,050	353	20	353		1,235	33
34		ARCHITECTS STUDIES		2003	120,149	6,007	20	6,007		21,025	34
35		MEDICARE WING CONST		2003	26,056	372	35	372		1,116	35
36		PAYMENTS TO ADVOCATE		2003	224,609	6,417	35	6,417		22,460	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning:

04/01/2005 Ending: 03/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILDING SIDING	2003	\$ 94,416	\$ 4,721	20	\$ 4,721	\$	\$ 16,523	37
38	PAYMENTS TO ADVOCATE	2004	321,482	4,593	35	4,593		13,779	38
39	SIDING	2004	5,914	148	20	148		444	39
40	ROOF	2004	18,632	466	20	466		1,398	40
41	FACILITIES MANAGEMENT	2004	67,311	1,682	20	1,682		5,046	41
42	PLUMBING	2004	47,360	1,184	20	1,184		3,552	42
43	FLOORING/CARPETING	2004	23,097	577	20	577		1,731	43
44	CONSTRUCTION/RENOVATION - DEMOLITION, CORING, M	2004	162,145	1,621	50	1,621		4,863	44
45	ASBESTOS REMOVAL	2004	8,522	213	20	213		639	45
46	ARCHITECTS SERVICES	2004	60,429	1,511	20	1,511		4,533	46
47	ELECTRICAL UPGRADES	2004	8,817	220	20	220		660	47
48	HEATING AND VENTILATION	2004	16,000	400	20	400		1,200	48
49	ARCHITECTS SERVICES	2004	161,357	2,305	35	2,305		6,915	49
50	CONSTRUCTION/RENOVATION - ELECTRICAL, FIRE PROT	2004	1,472,060	5,193	50	5,193		15,579	50
51	ARCHITECTS SERVICES	2004	9,278	232	20	232		696	51
52	ROOF	2004	7,723	193	20	193		579	52
53	PLUMBING	2004	10,757	269	20	269		807	53
54	CONSTRUCTION/RENOVATION - WALL CHANNELING, SHO	2004	135,355	1,353	50	1,353		4,059	54
55	CABINETS	2004	10,479	262	20	262		786	55
56	MC WING RENOVATION	2004	7,379	369	10	369		1,107	56
57	PAYMENTS TO ADVOCATE	2005	303,421	15,171	10	15,171		30,342	57
58	FACILITIES MANAGEMENT	2005	78,442	3,922	10	3,922		7,844	58
59	ROOF	2005	29,520	1,476	10	1,476		2,952	59
60	CONSTRUCTION/RENOVATION - CERAMIC TILE, PAINTING	2005	98,907	4,945	10	4,945		9,890	60
61	ARCHITECTS SERVICES	2005	6,367	318	10	318		636	61
62	ASBESTOS REMOVAL	2005	3,439	172	10	172		344	62
63	CONSTRUCTION/RENOVATION - STORM SEWER, PLUMBING	2005	138,844	6,942	10	6,942		13,884	63
64	CONSTRUCTION NEW VILLAS	2005	1,170,207	58,510	10	58,510		117,020	64
65	ARCHITECTS SERVICES	2005	24,566	1,228	10	1,228		2,456	65
66	CONSTRUCTION/RENOVATION - CARPENTRY, ELECTRICAL	2005	236,197	6,935	20	6,935		13,870	66
67	HCC renovation project demolition, carpentry, millwork	2006	414,807	20,740	20	20,740		20,740	67
68	electrical, fire protection, communications	2006	249,586	12,197	20	12,197		12,197	68
69	plumbing	2006	84,373	4,219	20	4,219		4,219	69
70	TOTAL (lines 4 thru 69)		\$ 15,087,664	\$ 461,296		\$ 461,296	\$	\$ 1,877,425	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 15,087,664	\$ 461,296		\$ 461,296	\$	\$ 1,877,425		1
2	Flooring/drywall/doors/painting	2006 244,473	12,224	20	12,224		12,224		2
3	architect service	2006 107,786	5,389	20	5,389		5,389		3
4	heating/AC	2006 91,699	4,585	20	4,585		4,585		4
5	room finish work appliances/beds/furniture/window treatments	2006 168,231	16,823	10	16,823		16,823		5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 15,699,853	\$ 500,317		\$ 500,317	\$	\$ 1,916,446		34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,097,232	\$ 113,897	\$ 113,897	\$		\$ 546,371	71
72	Current Year Purchases	57,696						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,154,928	\$ 113,897	\$ 113,897	\$		\$ 546,371	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUS	2003 FORD	2003	\$ 32,285	\$ 34,616	\$ 34,616	\$		\$ 76,823	76
77	BUS	2005 FORD	2005	94,681						77
78	VAN	2005 CHEVY	2006	16,885						78
79										79
80	TOTALS			\$ 143,851	\$ 34,616	\$ 34,616	\$		\$ 76,823	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,754,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 648,830	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 648,830	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,539,640	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	RETIREMENT LAND	\$ 1,606,903	\$	\$	86
87	RETIERMENT BUILDINGS	33,362,189	1,063,176	4,072,449	87
88	RETIREMENT EQUIPMENT	2,759,906	315,591	1,324,287	88
89					89
90					90
91	TOTALS	\$ 37,728,998	\$ 1,378,767	\$ 5,396,736	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning: 04/01/2005

Ending: 03/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2005 Ending: 03/31/2006

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>65</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>5</u></p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,035		2,035
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		47,121		47,121
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 49,156	\$	\$ 49,156
10	SUM OF line 9, col. 1 and 2 (e)	\$	49,156		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				144,551		144,551	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			\$		\$	\$ 144,551		\$ 144,551	14

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047Report Period Beginning: 04/01/2005Ending: 03/31/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 03/31/2006 (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	\$ 1,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,258,988		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	52,636		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,312,624	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,363,092		13
14	Buildings, at Historical Cost	49,062,043		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,058,685		16
17	Accumulated Depreciation (book methods)	(7,936,374)		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): <u>current account</u>	(2,248,327)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,299,119	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 46,611,743	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 970,184	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	398,653		28
29	Short-Term Notes Payable	150,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,518,837	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	660,511		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>deferred revenue</u>	34,428,199		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 35,088,710	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 36,607,547	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,004,196	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 46,611,743	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,602,896	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,602,896	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,401,300	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)	\$ 1,401,300	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)	\$ 10,004,196	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047Report Period Beginning: 04/01/2005Ending: 03/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 21,100,274	1
2	Discounts and Allowances for all Levels	(213,892)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,886,382	3
B. Ancillary Revenue			
4	Day Care	226,994	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 226,994	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	144,092	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	37,852	15
16	Rental of Facility Space	99,835	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)	\$ 281,779	23
D. Non-Operating Revenue			
24	Contributions	74,511	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 74,511	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)	\$ 21,469,666	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	6,004,599	31
32	Health Care	5,609,648	32
33	General Administration	6,248,500	33
B. Capital Expense			
34	Ownership	2,128,943	34
C. Ancillary Expense			
35	Special Cost Centers	76,676	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,068,366	40
41	Income before Income Taxes (line 30 minus line 40)**	1,401,300	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,401,300	43

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

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

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

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

Facility Name & ID Number **THE MOORINGS HEALTH CENTER**

0045047

Report Period Beginning: **04/01/2005**

Ending:

03/31/2006

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	1,601	1,991	\$ 72,831	\$ 36.58	1
2	Assistant Director of Nursing	1,868	2,080	63,942	30.74	2
3	Registered Nurses	36,977	40,748	1,422,696	34.91	3
4	Licensed Practical Nurses	4,682	5,586	80,657	14.44	4
5	CNAs & Orderlies	119,614	133,003	1,776,970	13.36	5
6	CNA Trainees					6
7	Licensed Therapist	6,797	7,864	222,649	28.31	7
8	Rehab/Therapy Aides	7,683	9,376	156,426	16.68	8
9	Activity Director	3,697	4,161	83,068	19.96	9
10	Activity Assistants	16,264	17,331	199,350	11.50	10
11	Social Service Workers	5,720	6,240	126,065	20.20	11
12	Dietician					12
13	Food Service Supervisor	10,093	11,126	121,545	10.92	13
14	Head Cook	17,980	19,804	239,122	12.07	14
15	Cook Helpers/Assistants	62,907	67,888	661,457	9.74	15
16	Dishwashers	4,766	5,112	41,493	8.12	16
17	Maintenance Workers	38,867	42,852	679,360	15.85	17
18	Housekeepers	63,185	68,659	664,116	9.67	18
19	Laundry					19
20	Administrator	3,521	4,160	221,279	53.19	20
21	Assistant Administrator					21
22	Other Administrative	14,871	14,871	593,216	39.89	22
23	Office Manager					23
24	Clerical	20,726	22,757	398,099	17.49	24
25	Vocational Instruction	1,784	1,784	125,231	70.20	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,398	1,583	20,341	12.85	31
32	Other Health Care(specify)					32
33	Other(specify) PUBLIC SAFETY	35,695	38,839	584,669	15.05	33
34	TOTAL (lines 1 - 33)	480,696	527,815	\$ 8,554,582 *	\$ 16.21	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		\$		35
36	Medical Director	480	45,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	50	2,000	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	530	\$ 47,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,723	\$ 286,151	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,723	\$ 286,151		53

Facility Name & ID Number **THE MOORINGS HEALTH CENTER**

0045047

Report Period Beginning: **04/01/2005**

Ending: **03/31/2006**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
MARY FITZGERALD	DIRECTOR	0	\$ 172,418	Workers' Compensation Insurance	\$ 96,302	IDPH License Fee	\$	
KATHY YOUNG	HCC ADMIN	0	100,017	Unemployment Compensation Insurance	1,041	Advertising: Employee Recruitment	12,578	
				FICA Taxes	191,688	Health Care Worker Background Check	2,268	
				Employee Health Insurance	247,582	(Indicate # of checks performed <u>62</u>)		
				Employee Meals	1,145	INSPECTIONS & LICENSE	867	
				Illinois Municipal Retirement Fund (IMRF)*		MEMBURSHIPS & PUBLICATIONS	9,235	
				LTD	1,289			
				RETIREMENT	213,838			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 272,435			Non-allowable advertising	()	
B. Administrative - Other						Yellow page advertising	()	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
OVERHEAD DEPARTMENTS ACCOUNTING, ADMINISTRATION, MARKETING, INFORMATION SERVICES, BOARD RELATIONS			\$ 2,122,450				\$ 24,948	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,122,450					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
MALCOLM JAMES	ACCOUNTING		\$ 11,311				Out-of-State Travel	\$
GARDNER, CARTON & DOUGLAS	LEGAL		28,118					
SEYFARTH, SHAW, FAIRWEATHER	LEGAL		2,530				In-State Travel	
GEORGE COVINGTON	LEGAL		1,418					
SONNENSCHN NATH & ROSEN	LEGAL		3,372				Seminar Expense	
WITT/KIEFFER	LEGAL		4,556					
EVANSTON INVENTURE			1,200				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 52,505				TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE MOORINGS HEALTH CENTER

Report Period Beginning: 04/01/2005 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	HEATING & VENTALA	3/2002	\$ 42,129	5	\$ 8,426	\$ 8,426	\$ 8,426	\$ 8,426	\$ 4,212				
2	OUTDOOR LIGHTING	3/2002	14,409	5	2,882	2,882	2,882	2,882	1,441				
3	HEATING & VENTALA	3/2003	43,053	5	4,305	8,611	8,611	8,611	8,610	4,305			
4	ELECTRICAL WIRING	3/2003	12,100	3	2,017	4,033	4,033	2,017					
5	PLUMBING	3/2003	15,080	3	2,513	5,027	5,027	2,513					
6	PAINTING & DECORAT	3/2003	3,750	3	625	1,250	1,250	625					
7	FOUNDATION	3/2003	4,170	4	521	1,043	1,043	1,043	520				
8	A/C & HEATING	3/2004	44,900	5		4,490	8,980	8,980	8,980	8,980	4,490		
9	ELECTRICAL WIRING	3/2004	4,530	3		755	1,510	1,510	755				
10	BOILER	3/2005	9,774	3			1,629	3,258	3,258	1,629			
11	HEATING & VENTALA	3/2005	30,680	5			3,068	6,136	6,136	6,136	6,136	3,068	
12	ELEVATORS	3/2005	18,650	3			3,108	6,217	6,217	3,108			
13	A/C	3/2005	11,631	3			1,939	3,877	3,877	1,938			
14	ELEVATORS	3/2006	18,224	3				3,037	6,075	6,075	3,037		
15	HEATING & VENTALA	3/2006	33,712	5				3,371	6,742	6,742	6,742	6,742	3,373
16	A/C	3/2006	28,930	3				4,822	9,643	9,643	4,822		
17													
18													
19													
20	TOTALS		\$ 335,722		\$ 21,289	\$ 36,517	\$ 51,506	\$ 67,325	\$ 66,466	\$ 48,556	\$ 25,227	\$ 9,810	\$ 3,373

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,977 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (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 during this cost report period. \$ 75,000
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 3,575 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? N/A
d. Have vehicle usage logs been maintained? N/A
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: DELOITTE 7 TOUCHE The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.