

		FOR BHF USE				

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

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

**I. IDPH License ID Number:** 0045047

**Facility Name:** THE MOORINGS HEALTH CENTER

**Address:** 761 OLD BARN LANE ARLINGTON HEIGHTS 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
<b>IRS Exemption Code</b> _____	<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 04/01/2006 to 03/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>ROBERT E. LANDSMAN</u>	
	(Title) <u>VICE-PRESIDENT OF FINANCE</u>	
<b>Paid Preparer</b>	(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: 04/01/2006 Ending: 03/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed 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	84	Skilled (SNF)	84	30,660	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,680	3
4		Intermediate/DD			4
5	67	Sheltered Care (SC)	67	24,455	5
6		ICF/DD 16 or Less			6
7	183	TOTALS	183	66,795	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	0	12,638	6,892	19,530	8
9	SNF/PED					9
10	ICF	2,251	15,601		17,852	10
11	ICF/DD					11
12	SC		11,800		11,800	12
13	DD 16 OR LESS					13
14	TOTALS	2,251	40,039	6,892	49,182	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.63%

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 CARE

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 10/01/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/2000 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 6,892

Medicare Intermediary ADMINSTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 03/31/2007 Fiscal Year: 03/31/2007

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2006 Ending: 03/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	1,478,257	61,961	76,108	1,616,326		1,616,326	(937,469)	678,857			1
2	Food Purchase		1,068,951		1,068,951	(40,052)	1,028,899	(596,761)	432,138			2
3	Housekeeping	679,407	67,869	56,412	803,688		803,688	(570,618)	233,070			3
4	Laundry											4
5	Heat and Other Utilities			863,825	863,825		863,825	(617,376)	246,449			5
6	Maintenance	676,695	167,518	474,561	1,318,774		1,318,774	(976,293)	342,481			6
7	Other (specify):* <b>Public Safety</b>	274,042	4,657	27,066	305,765		305,765	(218,530)	87,235			7
8	<b>TOTAL General Services</b>	<b>3,108,401</b>	<b>1,370,956</b>	<b>1,497,972</b>	<b>5,977,329</b>	<b>(40,052)</b>	<b>5,937,277</b>	<b>(3,917,047)</b>	<b>2,020,230</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director	85,977	853	45,127	131,957		131,957		131,957			9
10	Nursing and Medical Records	4,140,657	529,366	353,345	5,023,368	(374,422)	4,648,946		4,648,946			10
10a	Therapy	449,077	2,987	120,661	572,725		572,725		572,725			10a
11	Activities	329,705	10,451	64,129	404,285		404,285		404,285			11
12	Social Services	136,125	8,251	109,977	254,353	(116,121)	138,232		138,232			12
13	CNA Training	49,088	1,033	1,496	51,617		51,617		51,617			13
14	Program Transportation											14
15	Other (specify):* <b>Bad Debt</b>			12,182	12,182		12,182	(12,182)				15
16	<b>TOTAL Health Care and Programs</b>	<b>5,190,629</b>	<b>552,941</b>	<b>706,917</b>	<b>6,450,487</b>	<b>(490,543)</b>	<b>5,959,944</b>	<b>(12,182)</b>	<b>5,947,762</b>			16
	<b>C. General Administration</b>											
17	Administrative	245,830	22,951	1,527,618	1,796,399	(349,378)	1,447,021	(981,642)	465,379			17
18	Directors Fees											18
19	Professional Services			83,939	83,939	20,427	104,366	(76,590)	27,776			19
20	Dues, Fees, Subscriptions & Promotions			117,570	117,570	328,951	446,521	(497,513)	(50,992)			20
21	Clerical & General Office Expenses	257,859	46,787	177,291	481,937		481,937	(382,623)	99,314			21
22	Employee Benefits & Payroll Taxes			2,444,344	2,444,344	40,052	2,484,396	(1,775,599)	708,797			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,759	10,759		10,759	(10,759)				25
26	Insurance-Prop.Liab.Malpractice			241,025	241,025		241,025	(172,261)	68,764			26
27	Other (specify):* <b>Day Care</b>	366,155	1,853	119,198	487,206		487,206	(493,286)	(6,080)			27
28	<b>TOTAL General Administration</b>	<b>869,844</b>	<b>71,591</b>	<b>4,721,744</b>	<b>5,663,179</b>	<b>40,052</b>	<b>5,703,231</b>	<b>(4,390,273)</b>	<b>1,312,958</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>9,168,874</b>	<b>1,995,488</b>	<b>6,926,633</b>	<b>18,090,995</b>	<b>(490,543)</b>	<b>17,600,452</b>	<b>(8,319,502)</b>	<b>9,280,950</b>			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: 04/01/2006 Ending: 03/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			2,242,079	2,242,079		2,242,079	(1,602,853)	639,226		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			46,283	46,283		46,283		46,283		32
33	Real Estate Taxes			202,272	202,272		202,272	(175,977)	26,295		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,490,634	2,490,634		2,490,634	(1,778,830)	711,804		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					374,422	374,422		374,422		39
40	Barber and Beauty Shops					116,121	116,121		116,121		40
41	Coffee and Gift Shops		330		330		330		330		41
42	Provider Participation Fee			75,000	75,000		75,000		75,000		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		330	75,000	75,330	490,543	565,873		565,873		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	9,168,874	1,995,818	9,492,267	20,656,959		20,656,959	(10,098,332)	10,558,627		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: 04/01/2006

Ending: 03/31/2007

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (487,206)	27	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,080)	27		4
5	Telephone, TV & Radio in Resident Rooms	(38,183)	21		5
6	Rented Facility Space	(38,250)	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	(46,283)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,759)	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	(12,182)	15		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PG5A	(9,503,672)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (10,144,615)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</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		116,121	12	41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		374,422	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 490,543		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
**THE MOORINGS HEALTH CENTER**

ID# 0045047

Report Period Beginning: 04/01/2006

Ending: 03/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Dietary Retirement side	\$ (937,469)	1	1
2	Food Purchases	(596,761)	2	2
3	Housekeeping	(570,618)	3	3
4	Utilities	(617,376)	5	4
5	Mainteneace	(942,528)	6	5
6	Public Safety	(218,530)	7	6
7	Deferred Mainteneace Adjustment	4,485	6	7
8	Administrative	(1,034,186)	17	8
9	Professional Services	(74,590)	19	9
10	Dues Fees Subscription	(408,321)	20	10
11	Clerical	(344,440)	21	11
12	Employee Benefits	(1,775,599)	22	12
13	Insurance	(172,261)	26	13
14	Nurse administrator add back	52,544	17	14
15	Depreciation	(1,602,853)	30	15
16	Real Estate Taxes	(175,977)	33	16
17	Non Allowable membership & Publuications	(89,192)	20	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(9,503,672)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning:

04/01/2006

Ending:

03/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(937,469)	0	0	0	0	0	0	0	0	0	0	(937,469)	1
2	Food Purchase	(596,761)	0	0	0	0	0	0	0	0	0	0	(596,761)	2
3	Housekeeping	(570,618)	0	0	0	0	0	0	0	0	0	0	(570,618)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(617,376)	0	0	0	0	0	0	0	0	0	0	(617,376)	5
6	Maintenance	(976,293)	0	0	0	0	0	0	0	0	0	0	(976,293)	6
7	Other (specify):*	(218,530)	0	0	0	0	0	0	0	0	0	0	(218,530)	7
8	<b>TOTAL General Services</b>	<b>(3,917,047)</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>(3,917,047)</b>	<b>8</b>
	<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	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):*	(12,182)	0	0	0	0	0	0	0	0	0	0	(12,182)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(12,182)</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>(12,182)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(981,642)	0	0	0	0	0	0	0	0	0	0	(981,642)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(76,590)	0	0	0	0	0	0	0	0	0	0	(76,590)	19
20	Fees, Subscriptions & Promotions	(497,513)	0	0	0	0	0	0	0	0	0	0	(497,513)	20
21	Clerical & General Office Expenses	(382,623)	0	0	0	0	0	0	0	0	0	0	(382,623)	21
22	Employee Benefits & Payroll Taxes	(1,775,599)	0	0	0	0	0	0	0	0	0	0	(1,775,599)	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	(10,759)	0	0	0	0	0	0	0	0	0	0	(10,759)	25
26	Insurance-Prop.Liab.Malpractice	(172,261)	0	0	0	0	0	0	0	0	0	0	(172,261)	26
27	Other (specify):*	(493,286)	0	0	0	0	0	0	0	0	0	0	(493,286)	27
28	<b>TOTAL General Administration</b>	<b>(4,390,273)</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>(4,390,273)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(8,319,502)</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>(8,319,502)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047

Report Period Beginning:

04/01/2006 Ending:

Summary B

03/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(1,602,853)	0	0	0	0	0	0	0	0	0	0	(1,602,853)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46,283)	0	0	0	0	0	0	0	0	0	0	(46,283)	32
33	Real Estate Taxes	(175,977)	0	0	0	0	0	0	0	0	0	0	(175,977)	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	<b>TOTAL Ownership</b>	<b>(1,825,113)</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>(1,825,113)</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 Centers</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>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(10,144,615)</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>(10,144,615)</b>	<b>45</b>

Facility Name & ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning: 04/01/2006 Ending: 03/31/2007

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	9 MEDICAL DIRECTOR	\$ 158,663	PRESBYTERIAN HOMES	100.00%	\$ 158,663	\$	1
2	V	17 INFORMATION SYSTEMS	166,542	PRESBYTERIAN HOMES	100.00%	166,542		2
3	V	17 OVERHEAD ADMINISTRATION	3,179,010	PRESBYTERIAN HOMES	100.00%	3,179,010		3
4	V	17 MARKETING	718,084	PRESBYTERIAN HOMES	100.00%	718,084		4
5	V	17 ACCOUNTING SERVICES	385,818	PRESBYTERIAN HOMES	100.00%	385,818		5
6	V	17 HUMAN SERVICES	224,079	PRESBYTERIAN HOMES	100.00%	224,079		6
7	V	17 BOARD ADMINISTRATION	51,503	PRESBYTERIAN HOMES	100.00%	51,503		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 4,883,699			\$ 4,883,699	\$ *	14

\* 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: 04/01/2006 Ending: 03/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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: 04/01/2006

Ending: 3/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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	\$ 158,663	\$ 85,977		\$ 0	1
2	17	INFORMATION SYSTEMS	DIRECT COST	1	166,542	92,995		0	2
3	17	OVERHEAD ADMINISTRATIO	DIRECT COST	1	3,179,010	151,879		0	3
4	17	MARKETING	DIRECT COST	1	718,084	275,236		0	4
5	17	ACCOUNTING SERVICES	DIRECT COST	1	385,818	218,923		0	5
6	17	HUMAN SERVICES	DIRECT COST	1	224,079	125,905		0	6
7	17	BOARD ADMINISTRATION	DIRECT COST	1	51,503	12,563		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				\$ 4,883,699	\$ 963,478		\$	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	PRESBYTERIAN HOMES	X		IMPUTED INTEREST ON PURCHASE PRICE					\$ 46,283	1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>				\$	\$			\$ 46,283	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>				\$	\$				14										
15	<b>TOTALS (line 9+line14)</b>				\$	\$			\$ 46,283	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

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

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-10-113-004-0000</u>	<u>ASSISTED LIVING &amp; HEALTH CEN</u>	\$ <u>117,002.82</u>	\$ <u>117,002.82</u>
2. <u>08-10-113-003-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>78,655.62</u>	\$ _____
3. <u>08-10-113-002-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>8,854.70</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>204,513.14</u>	\$ <u>117,002.82</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

# 0045047 Report Period Beginning:

04/01/2006 Ending:

03/31/2007

**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 71% of the census resideing 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 the 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>769,305</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>769,305</u>	3

Facility Name &amp; ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning:

04/01/2006 Ending: 03/31/2007

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	183		2000	1994	\$ 8,656,752	\$ 249,178	35	\$ 249,178		\$ 1,620,577	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		JENSEN HALSTEAD ARCHITECTS		2001	2,796	280	10	280		1,820	9
10		PAYMENTS TO ADVOCATE		2002	10,724	306	35	306		1,683	10
11		FACILITIES MANAGEMENT		2002	16,844	1,684	10	1,684		9,262	11
12		DECORATING		2002	5,459	546	10	546		3,003	12
13		FLOORING		2002	5,011	501	10	501		2,756	13
14		CABLING, CAMERAS, SOUND SYSTEM		2002	16,165	1,617	10	1,617		8,889	14
15		POOL REPAIRS		2002	4,789	479	10	479		2,634	15
16		HEATING & VENTILATION		2002	13,303	1,330	10	1,330		7,315	16
17		CABINETS		2002	938	94	10	94		517	17
18		DOOR LOCKS		2002	705	71	10	71		390	18
19		SHELTERED CARE ARCHITECTS		2002	13,065	653	20	653		3,892	19
20		VILLA ARCHITECTS		2002	17,574	879	20	879		4,834	20
21		BUILDING SIDING		2002	150,792	7,540	20	7,540		41,470	21
22		ARCHITECTS STUDIES		2002	18,109	905	20	905		4,978	22
23		CABINETS		2002	448	22	20	22		121	23
24		FOOD SERVICE EQUIPMENT		2002	512	26	20	26		143	24
25		FACILITIES MANAGEMENT		2003	27,833	2,783	10	2,783		12,524	25
26		CABLING, CAMERAS, SOUND SYSTEM		2003	5,490	549	10	549		2,471	26
27		DECORATING		2003	20,475	2,048	10	2,048		9,216	27
28		FIRE ALARM SYSTEMS		2003	12,565	1,257	10	1,257		5,656	28
29		CABINETS		2003	36,787	1,839	20	1,839		8,276	29
30		ELECTRICAL WIRING		2003	42,505	2,125	20	2,125		9,563	30
31		HEATING & VENTILATION		2003	90,418	4,521	20	4,521		20,344	31
32		ARCHITECTS STUDIES		2003	52,552	2,628	20	2,628		11,826	32
33		ASBESTOS REMOVAL		2003	7,050	353	20	353		1,588	33
34		ARCHITECTS STUDIES		2003	120,149	6,007	20	6,007		27,032	34
35		MEDICARE WING CONSTRUCTION		2003	26,056	744	35	744		1,860	35
36		PAYMENTS TO ADVOCATE		2003	224,609	6,417	35	6,417		28,877	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 &amp; ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning:

04/01/2006 Ending: 03/31/2007

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BUILDING SIDING	2003	\$ 94,416	\$ 9,442	10	\$ 9,442	\$	\$ 21,244	37
38	PAYMENTS TO ADVOCATE	2004	321,482	9,185	35	9,185		22,964	38
39	SIDING	2004	5,914	296	20	296		740	39
40	ROOF	2004	18,632	932	20	932		2,330	40
41	FACILITIES MANAGEMENT	2004	67,311	3,366	20	3,366		8,412	41
42	PLUMBING	2004	47,360	2,368	20	2,368		5,920	42
43	FLOORING/CARPETING	2004	23,097	1,155	20	1,155		2,886	43
44	CONSTRUCTION/RENOVATION-DEMOLITION, CORING	2004	162,145	3,243	50	3,243		8,106	44
45	ASBESTOS REMOVAL	2004	8,522	426	20	426		1,065	45
46	ARCHITECTS SERVICES	2004	60,429	3,021	20	3,021		7,554	46
47	ELECTRICAL UPGRADES	2004	8,817	441	20	441		1,101	47
48	HEATING AND VENTILATION	2004	16,000	800	20	800		2,000	48
49	ARCHITECTS SERVICES	2004	161,357	4,610	35	4,610		11,525	49
50	CONSTRUCTION/RENOVATION-ELECTRICAL, FIRE PROTE	2004	1,472,060	29,441	50	29,441		45,020	50
51	ARCHITECTS SERVICES	2004	9,278	464	20	464		1,160	51
52	ROOF	2004	7,723	386	20	386		965	52
53	PLUMBING	2004	10,757	538	20	538		1,117	53
54	CONSTRUCTION/RENOVATION-WALL CHANNELING	2004	135,355	2,707	50	2,707		3,514	54
55	CABINETS	2004	10,479	524	20	524		1,310	55
56	MC WING RENOVATION	2004	7,379	738	10	738		1,845	56
57	PAYMENTS TO ADVOCATE	2005	303,421	8,669	35	8,669		60,684	57
58	FACILITIES MANAGEMENT	2005	78,442	7,844	10	7,844		15,688	58
59	ROOF	2005	29,520	2,952	10	2,952		5,904	59
60	CONSTRUCTION/RENOVATION-CEAMIC TILE, PAINTING	2005	98,907	9,891	10	9,891		19,781	60
61	ARCHITECTS SERVICES	2005	6,367	637	10	637		1,273	61
62	ASBESTOS REMOVAL	2005	3,439	344	10	344		688	62
63	CONSTRUCTION/RENOVATION-STORM SEWER, PLUMBING	2005	138,844	13,884	10	13,884		27,768	63
64	CONSTRUCTION NEW VILLAS	2005	1,170,207	23,404	50	23,404		234,041	64
65	ARCHITECTS SERVICES	2005	24,566	2,457	10	2,457		4,913	65
66	CONSTRUCTION/RENOVATION-CARPENTRY, ELECTRICAL	2005	236,197	11,810	20	11,810		25,680	66
67	HCC RENOVATION PROJECT DEMOLITION, CARPENTRY	2006	414,807	20,740	20	20,740		41,480	67
68	ELECTRICAL, FIRE PROTECTION, COMMUNICATIONS	2006	249,586	7,131	35	7,131		24,676	68
69	PLUMBING	2006	84,373	4,219	20	4,219		8,438	69
70	TOTAL (lines 4 thru 69)		\$ 15,087,664	\$ 485,445		\$ 485,445	\$	\$ 2,475,309	70

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning:

04/01/2006 Ending: 03/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,087,664	\$ 485,445		\$ 485,445	\$	\$ 2,475,309	1
2	FLOORING/DRYWALL/DOORS/PAINTING	2006	244,473	12,224	20	12,224	0	24,448	2
3	ARCHITECTS SERVICES	2006	107,786	5,389	20	5,389		10,778	3
4	HEATING/AC	2006	91,699	4,585	20	4,585		9,170	4
5	ROOM FINISH WORK APPLIANCES/BEDS/FURNITURE/WIN	2006	168,231	16,823	10	16,823		33,646	5
6	PAYMENTS TO ADVOCATE-AUDIT	2007	(90,953)	(1,299)	35		1,299		6
7	ARCHITECTS SERVICES	2007	715	36	10	36		36	7
8	ARCHITECTS SERVICES	2007	11,504	288	20	288		288	8
9	CONSTRUCTION/RENOVATION RESIDENTS C	2007	24,604	351	35	351		351	9
10	FACILITIES MANAGEMENT	2007	53,271	1,332	20	1,332		2,664	10
11	MID-RISE ROOF REPLACEMENT	2007	68,762	1,719	20	1,719		3,438	11
12	ROOF REPLACEMENT	2007	3,322	47	35	47		47	12
13	RENOVATION IND HEALTH CARE APTS	2007	36,060	902	20	902		902	13
14	RENOVATION KITCHEN/DINING SVCS	2007	25,072	1,254	10	1,254		1,254	14
15	RENOVATION SHELTERED CARE WINDOWS	2007	7,003	350	10	350		350	15
16	RENOVATION/CONSTRUCTION MEDICARE WING	2007	35,818	1,791	10	1,791		1,791	16
17	RENOVATION/CONSTRUCTION SHELTERED CARE	2007	219,800	5,495	20	5,495		10,990	17
18	CONSTRUCTION/RENOVATION -VILLAS	2007	6,772	68	50	68		68	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	TOTAL (lines 1 thru 33)		\$ 16,101,603	\$ 536,799		\$ 538,099	\$ 1,300	\$ 2,575,530	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	\$ 1,154,928	\$ 88,660	\$ 88,660	\$		\$ 635,031	71
72	Current Year Purchases	93,905						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,248,833	\$ 88,660	\$ 88,660	\$		\$ 635,031	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	\$ 32,285	\$ 12,467	\$ 12,467	\$		\$ 89,290	76
77	BUS		2005	94,681						77
78	VAN		2006	16,885						78
79	AUTO		2007	1,939						79
80	TOTALS			\$ 145,790	\$ 12,467	\$ 12,467	\$		\$ 89,290	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)	\$ 18,265,531	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 637,926	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 639,226	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,300	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,299,851	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	\$ 1,639,015	\$	\$	86
87	RETIREMENT BUILDINGS	34,345,786	1,118,235	5,190,684	87
88	RETIREMENT EQUIPMENT	2,994,556	363,633	1,687,920	88
89					89
90					90
91	TOTALS	\$ 38,979,357	\$ 1,481,868	\$ 6,878,604	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: 04/01/2006

Ending: 03/31/2007

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

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

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

9. Option to Buy:  YES  NO      Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,529		2,529
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		49,088		49,088
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 51,617	\$	\$ 51,617
10	SUM OF line 9, col. 1 and 2 (e)	\$	51,617		

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	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
<b>TOTAL TRAINED</b>	<input style="width: 100px;" type="text"/>

- (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				374,422		374,422	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	<b>TOTAL</b>			\$		\$	\$ 374,422		\$ 374,422	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: 04/01/2006

Ending:

03/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 03/31/2007

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,135,393		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	496,655		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>	\$ 1,633,048	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,408,320		13
14	Buildings, at Historical Cost	50,447,389		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,389,179		16
17	Accumulated Depreciation (book methods)	(10,178,455)		17
18	Deferred Charges	110,914		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>	(2,761,402)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 44,415,945	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 46,048,993	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 6,195,900	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	450,992		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,796,892	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	511,311		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>deferred revenue</u>	40,634,914		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 41,146,225	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 47,943,117	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,894,124)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 46,048,993	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,004,196	1
2	Restatements (describe):	(11,656,639)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,652,443)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(241,681)	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)	\$ (241,681)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,894,124)	24 *

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER

# 0045047

Report Period Beginning: 04/01/2006

Ending: 03/31/2007

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 20,279,076	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 20,279,076	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	152,125	24
25	Interest and Other Investment Income***	(46,283)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 105,842	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			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>	\$ 20,384,918	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	5,977,329	31
32	Health Care	6,450,487	32
33	General Administration	5,663,179	33
<b>B. Capital Expense</b>			
34	Ownership	2,490,634	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	net assets released	44,970	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 20,626,599	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(241,681)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (241,681)	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.

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

# **0045047**

Report Period Beginning: **04/01/2006**

Ending:

**03/31/2007**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,848	2,080	\$ 79,464	\$ 38.20	1
2	Assistant Director of Nursing	1,771	2,080	65,527	31.50	2
3	Registered Nurses	60,353	63,669	1,722,906	27.06	3
4	Licensed Practical Nurses	5,878	6,277	121,510	19.36	4
5	CNAs & Orderlies	143,868	156,491	1,835,245	11.73	5
6	CNA Trainees					6
7	Licensed Therapist	4,256	4,599	142,463	30.98	7
8	Rehab/Therapy Aides	5,421	5,939	120,764	20.33	8
9	Activity Director	5,369	6,296	128,801	20.46	9
10	Activity Assistants	16,615	18,091	226,129	12.50	10
11	Social Service Workers	5,474	6,101	123,762	20.29	11
12	Dietician					12
13	Food Service Supervisor	10,909	12,028	147,383	12.25	13
14	Head Cook	18,283	19,820	262,881	13.26	14
15	Cook Helpers/Assistants	85,797	90,533	722,446	7.98	15
16	Dishwashers	9,786	10,088	80,251	7.96	16
17	Maintenance Workers	31,625	35,613	597,096	16.77	17
18	Housekeepers	70,322	77,459	704,682	9.10	18
19	Laundry					19
20	Administrator	1,675	2,080	147,400	70.87	20
21	Assistant Administrator					21
22	Other Administrative	18,125	18,125	725,000	40.00	22
23	Office Manager					23
24	Clerical	20,958	22,745	370,411	16.29	24
25	Vocational Instruction	4,185	4,185	104,637	25.00	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	1,345	1,479	20,175	13.64	31
32	Other Health Care(specify)					32
33	Other(specify) <b>Public Safety</b>	42,659	46,715	719,941	15.41	33
34	<b>TOTAL (lines 1 - 33)</b>	<b>566,522</b>	<b>612,493</b>	<b>\$ 9,168,874 *</b>	<b>\$ 14.97</b>	<b>34</b>

\* 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				39
40	Physical Therapy Consultant	995	52,786		40
41	Occupational Therapy Consultant	1,250	66,226		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	<b>TOTAL (lines 35 - 48)</b>	<b>2,725</b>	<b>\$ 164,012</b>		<b>49</b>

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,469	\$ 225,497	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	<b>TOTAL (lines 50 - 52)</b>	<b>3,469</b>	<b>\$ 225,497</b>		<b>53</b>

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

# **0045047**

Report Period Beginning: **04/01/2006**

Ending: **03/31/2007**

**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		\$ 171,824	Workers' Compensation Insurance	\$ 44,938	IDPH License Fee	\$		
KATHY WAGNER	HCC ADMIN		74,006	Unemployment Compensation Insurance	978	Advertising: Employee Recruitment	21,739		
				FICA Taxes	190,540	Health Care Worker Background Check	3,473		
				Employee Health Insurance	245,326	(Indicate # of checks performed <u>62</u> )			
				Employee Meals	2,566	<b>MEMBERSHIPS &amp; PUBLICATIONS</b>	10,859		
				Illinois Municipal Retirement Fund (IMRF)*		<b>INSPECTIONS &amp; LICENSE</b>	2,129		
				RETIREMENT	218,242				
				LTD	6,207				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 245,830						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
OVERHEAD DEPARTMENTS ACCOUNTING, ADMINISTRATION, MARKETING, INFORMATION SERVICES & BOARD RELATIONS			\$ 1,527,618				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,527,618	TOTAL			TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,200
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
MALCOLM, JAMES	ACCOUNTING	\$ 1,700							
PETER GRABOWSKI	ACCOUNTING	54							
UNGARETTI & HARRIS	LEGAL	463							
DELOITTE & TOUCHE	AUDITING	4,500							
SONNENSCHNEIN, NATH & ROS	LEGAL	29,851							
GARDNER, CARTON & DOUG	LEGAL	20,332							
SEYFARTH, SHAW, FAIRWEAT	LEGAL	13,004							
WITT/KIEFFER, FORD, HADEL	LEGAL	5,520							
DRINKER, BIDDLE, REATH	LEGAL	4,539							
GEORGE COVINGTON	LEGAL	1,958							
BOLLMAN, LESSER	CONSULTING	2,018							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 83,939						

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number THE MOORINGS HEALTH CENTER

Report Period Beginning: 04/01/2006 Ending: 03/31/2007

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	HEATING & VENTILAT	3/2002	\$ 42,129	5	\$ 8,426	\$ 8,426	\$ 8,426	\$ 4,212					
2	OUTDOOR LIGHTING	3/2002	14,409	5	2,882	2,882	2,882	1,441					
3	HEATING & VENTILAT	3/2003	43,053	5	8,611	8,611	8,611	8,610	4,305				
4	ELECTRICAL WIRING	3/2003	12,100	3	4,033	4,033	2,017						
5	PLUMBING	3/2003	15,080	3	5,027	5,027	2,513						
6	PAINTING & DECORAT	3/2003	3,750	3	1,250	1,250	625						
7	FOUNDATION	3/2003	4,170	4	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 & VENTILAT	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 & HEATING	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 & VENTILAT	3/2006	33,712	5			3,371	6,742	6,742	6,742	6,742	3,373	
16	A/C & HEATING	3/2006	28,930	3			4,822	9,643	9,643	4,822			
17	ELEVATORS	3/2007	19,989	3				3,332	6,663	6,663	3,331		
18	ROOF MAINTENANCE	3/2007	30,232	5				3,024	6,046	6,046	6,046	6,046	3,024
19	A/C & HEATING	3/2007	47,782	3				7,964	15,927	15,927	7,964		
20	TOTALS		\$ 433,725		\$ 36,517	\$ 51,506	\$ 67,325	\$ 80,786	\$ 77,192	\$ 53,863	\$ 27,151	\$ 9,419	\$ 3,024

**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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	<b>TOTALS PAGE 22</b>	\$ 433,725		\$ 36,517	\$ 51,506	\$ 67,325	\$ 80,786	\$ 77,192	\$ 53,863	\$ 27,151	\$ 9,419	\$ 3,024
2	<b>HEATING &amp; VENTILAT</b>	3/2007 7,278		0	0	0	727	1,456	1,456	1,456	1,456	727
3	<b>BOILER</b>	3/2007 7,648		0	0	0	1,275	2,549	2,549	1,275		
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20	<b>TOTALS</b>	\$ 448,651		\$ 36,517	\$ 51,506	\$ 67,325	\$ 82,788	\$ 81,197	\$ 57,868	\$ 29,882	\$ 10,875	\$ 3,751

Facility Name &amp; ID Number THE MOORINGS HEALTH CENTER

**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. \$ 27,716 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. \$ 40,052 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 & 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 \$5,000, 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.