

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047 Report Period Beginning: 04/01/2007 Ending: 03/31/2008

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	<u>84</u>	Skilled (SNF)	<u>84</u>	<u>30,744</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>32</u>	Intermediate (ICF)	<u>32</u>	<u>11,712</u>	3
4		Intermediate/DD			4
5	<u>67</u>	Sheltered Care (SC)	<u>67</u>	<u>24,522</u>	5
6		ICF/DD 16 or Less			6
7	<u>183</u>	TOTALS	<u>183</u>	<u>66,978</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>1,867</u>	<u>12,561</u>	<u>7,924</u>	<u>22,352</u>	8
9	SNF/PED					9
10	ICF		<u>14,234</u>		<u>14,234</u>	10
11	ICF/DD					11
12	SC		<u>12,110</u>		<u>12,110</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,867</u>	<u>38,905</u>	<u>7,924</u>	<u>48,696</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.70%

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)
_____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 84 and days of care provided 7,924Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 03/31/2008 Fiscal Year: 03/31/2008

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

Facility Name & ID Number THE MOORINGS HEALTH CENTER # 0045047 Report Period Beginning: 04/01/2007 Ending: 03/31/2008

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
	A. General Services										
1	Dietary	1,427,458	82,824	85,994	1,596,276		1,596,276	(925,840)	670,436		1
2	Food Purchase		1,214,968		1,214,968	(59,410)	1,155,558	(670,224)	485,334		2
3	Housekeeping	679,968	70,400	51,338	801,706		801,706	(569,211)	232,495		3
4	Laundry										4
5	Heat and Other Utilities			867,214	867,214		867,214	(619,798)	247,416		5
6	Maintenance	702,619	206,910	605,008	1,514,537		1,514,537	(1,121,863)	392,674		6
7	Other (specify):* Public Safety	274,427	10,209	51,975	336,611		336,611	(240,576)	96,035		7
8	TOTAL General Services	3,084,472	1,585,311	1,661,529	6,331,312	(59,410)	6,271,902	(4,147,512)	2,124,390		8
	B. Health Care and Programs										
9	Medical Director	26,084	181	45,010	71,275		71,275		71,275		9
10	Nursing and Medical Records	4,296,403	643,428	494,944	5,434,775	(429,181)	5,005,594		5,005,594		10
10a	Therapy	485,275	5,037	196,701	687,013		687,013		687,013		10a
11	Activities	330,132	11,799	71,217	413,148		413,148		413,148		11
12	Social Services	94,106	4,714	100,643	199,463	(101,454)	98,009		98,009		12
13	CNA Training	79,583	504	2,314	82,401		82,401		82,401		13
14	Program Transportation										14
15	Other (specify):* Bad Debt										15
16	TOTAL Health Care and Programs	5,311,583	665,663	910,829	6,888,075	(530,635)	6,357,440		6,357,440		16
	C. General Administration										
17	Administrative	214,767	52,148	1,712,949	1,979,864	(431,568)	1,548,296	(1,106,567)	441,729		17
18	Directors Fees										18
19	Professional Services			56,977	56,977	19,576	76,553	(54,712)	21,841		19
20	Dues, Fees, Subscriptions & Promotions			124,147	124,147	411,992	536,139	(536,139)			20
21	Clerical & General Office Expenses	273,621	57,128	250,297	581,046		581,046	(450,142)	130,904		21
22	Employee Benefits & Payroll Taxes			2,428,541	2,428,541	59,410	2,487,951	(1,778,139)	709,812		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,001	7,001		7,001	(7,001)			25
26	Insurance-Prop.Liab.Malpractice			212,480	212,480		212,480	(151,859)	60,621		26
27	Other (specify):* day care	323,840	2,145	104,300	430,285		430,285	(430,285)			27
28	TOTAL General Administration	812,228	111,421	4,896,692	5,820,341	59,410	5,879,751	(4,514,844)	1,364,907		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,208,283	2,362,395	7,469,050	19,039,728	(530,635)	18,509,093	(8,662,356)	9,846,737		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: 04/01/2007 Ending: 03/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			2,304,302	2,304,302		2,304,302	(1,646,885)	657,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,148	43,148		43,148	(43,148)				32
33	Real Estate Taxes			208,000	208,000		208,000	(180,960)	27,040			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,555,450	2,555,450		2,555,450	(1,870,993)	684,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					429,181	429,181		429,181			39
40	Barber and Beauty Shops					101,454	101,454		101,454			40
41	Coffee and Gift Shops		716		716		716		716			41
42	Provider Participation Fee		75,000		75,000		75,000		75,000			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		75,716		75,716	530,635	606,351		606,351			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,208,283	2,438,111	10,024,500	21,670,894		21,670,894	(10,533,349)	11,137,545			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: 04/01/2007

Ending: 03/31/2008

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(34,868)	21		5
6	Rented Facility Space	(37,800)	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	(43,148)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(7,001)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule pg5a	(10,410,532)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,533,349)		\$	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))	\$ (10,533,349)		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.

		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		101,454	12	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	X		429,181	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 530,635		47

BHF USE ONLY					
48		49		50	51
					52

STATE OF ILLINOIS
THE MOORINGS HEALTH CENTER

ID# 0045047

Report Period Beginning: 04/01/2007

Ending: 03/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Dietary Retirement side	\$ (925,840)	1	1
2	Food Purchases	(670,224)	2	2
3	Housekeeping	(569,211)	3	3
4	Utilities	(619,798)	5	4
5	Mainteneace	(1,082,440)	6	5
6	Public Safety	(240,576)	7	6
7	Administrative	(1,106,567)	17	7
8	Professional Services	(54,712)	19	8
9	Dues Fees Subscription	(536,139)	20	9
10	Clerical	(415,274)	21	10
11	Employee Benefits	(1,778,139)	22	11
12	Insurance	(151,859)	26	12
13	Adult Day care	(430,285)	27	13
14	Depreciation	(1,646,885)	30	14
15	Real Estate Taxes	(180,960)	33	15
16	Deferred Maintenance	(1,623)	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,410,532)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning:

04/01/2007

Ending:

03/31/2008

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	(925,840)	0	0	0	0	0	0	0	0	0	0	(925,840)	1
2	Food Purchase	(670,224)	0	0	0	0	0	0	0	0	0	0	(670,224)	2
3	Housekeeping	(569,211)	0	0	0	0	0	0	0	0	0	0	(569,211)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(619,798)	0	0	0	0	0	0	0	0	0	0	(619,798)	5
6	Maintenance	(1,121,863)	0	0	0	0	0	0	0	0	0	0	(1,121,863)	6
7	Other (specify):*	(240,576)	0	0	0	0	0	0	0	0	0	0	(240,576)	7
8	TOTAL General Services	(4,147,512)	0	0	0	0	0	0	0	0	0	0	(4,147,512)	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	(1,106,567)	0	0	0	0	0	0	0	0	0	0	(1,106,567)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(54,712)	0	0	0	0	0	0	0	0	0	0	(54,712)	19
20	Fees, Subscriptions & Promotions	(536,139)	0	0	0	0	0	0	0	0	0	0	(536,139)	20
21	Clerical & General Office Expenses	(450,142)	0	0	0	0	0	0	0	0	0	0	(450,142)	21
22	Employee Benefits & Payroll Taxes	(1,778,139)	0	0	0	0	0	0	0	0	0	0	(1,778,139)	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	(7,001)	0	0	0	0	0	0	0	0	0	0	(7,001)	25
26	Insurance-Prop.Liab.Malpractice	(151,859)	0	0	0	0	0	0	0	0	0	0	(151,859)	26
27	Other (specify):*	(430,285)	0	0	0	0	0	0	0	0	0	0	(430,285)	27
28	TOTAL General Administration	(4,514,844)	0	0	0	0	0	0	0	0	0	0	(4,514,844)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,662,356)	0	0	0	0	0	0	0	0	0	0	(8,662,356)	29

STATE OF ILLINOIS

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047

Report Period Beginning:

04/01/2007 Ending:

Summary B

03/31/2008

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	(1,646,885)	0	0	0	0	0	0	0	0	0	0	(1,646,885)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(43,148)	0	0	0	0	0	0	0	0	0	0	(43,148)	32
33	Real Estate Taxes	(180,960)	0	0	0	0	0	0	0	0	0	0	(180,960)	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	(1,870,993)	0	(1,870,993)	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)	(10,533,349)	0	(10,533,349)	45									

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning: 04/01/2007 Ending: 03/31/2008

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
		McGaw Care Center	Evanston	Presbyterian Homes	Evanston	Home Health
		Balmoral Care Center	Lake Forest	Presbyterian Homes	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	\$ 71,275	Presbyterian Homes	100.00%	\$ 71,275	\$
2	V	17 Information Systems	122,389	Presbyterian Homes	100.00%	122,389	
3	V	17 Overhead Administration	201,633	Presbyterian Homes	100.00%	201,633	
4	V	17 Marketing	791,809	Presbyterian Homes	100.00%	791,809	
5	V	17 Accounting Services	326,247	Presbyterian Homes	100.00%	326,247	
6	V	17 Human Resources	208,499	Presbyterian Homes	100.00%	208,499	
7	V	17 Board Administration	50,624	Presbyterian Homes	100.00%	50,624	
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,772,476			\$ 1,772,476	\$ *

* 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: 04/01/2007 Ending: 03/31/2008

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									\$		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: 04/01/2007

Ending: 3/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	9	Medical Director	Direct Cost	1	\$ 71,275	\$ 26,084	1	\$ 71,275	1
2	17	Information Systems	Direct Cost	1	122,389	106,535	1	122,389	2
3	17	Overhead Administration	Direct Cost	1	201,633	155,542	1	201,633	3
4	17	Marketing	Direct Cost	1	791,809	317,438	1	791,809	4
5	17	Accounting Services	Direct Cost	1	326,247	242,773	1	326,247	5
6	17	Human Resources	Direct Cost	1	208,499	142,962	1	208,499	6
7	17	Board Administration	Direct Cost	1	50,624	14,409	1	50,624	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				\$ 1,772,476	\$ 1,005,742		\$ 1,772,476	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						\$ 43,148	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 43,148	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 43,148	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 2007 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.)		\$ 115,114	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 115,114	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 92,886	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.		\$ 208,000	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	109,502	8
	2004	114,043	9
	2005	105,255	10
	2006	117,003	11
	2007	208,000	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 & HEALTH CEN</u>	\$ <u>115,113.66</u>	\$ <u>115,113.66</u>
2. <u>08-10-113-003-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>77,385.68</u>	\$ _____
3. <u>08-10-113-002-0000</u>	<u>RETIREMENT CENTER</u>	\$ <u>2,990.73</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>195,490.07</u>	\$ <u>115,113.66</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

04/01/2007 Ending:

03/31/2008

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 72% of the census residing in the Retirement Community

All of the Adult Day Care costs were adjusted out due to the discontinuation of the program.

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>745,310</u>	1
2					2
3	TOTALS			\$ <u>745,310</u>	3

Facility Name & ID Number THE MOORINGS HEALTH CENTER

0045047

Report Period Beginning:

04/01/2007 Ending: 03/31/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	183		2000	1994	\$ 8,656,752	\$ 249,178	35	\$ 249,178	\$	\$ 1,869,755	4
5				2008	(2,420,590)				(2,420,590)	(578,191)	5
6											6
7											7
8											8
	Improvement Type**										
9	Jensen Halstead Architects		2001		2,796	280	10	280		2,100	9
10	Payments to Advocate		2002		10,724	306	35	306		1,989	10
11	Facilities Management		2002		16,844	1,684	10	1,684		10,946	11
12	Decorating		2002		5,459	546	10	546		3,549	12
13	Flooring		2002		5,011	501	10	501		3,257	13
14	Cabling, Cameras, Sound System		2002		16,165	1,617	10	1,617		10,506	14
15	Pool Repairs		2002		4,789	479	10	479		3,113	15
16	Heating & Ventilation		2002		13,303	1,330	10	1,330		8,645	16
17	Cabinets		2002		938	94	10	94		611	17
18	Door Locks		2002		705	71	10	71		461	18
19	Sheltered Care Architects		2002		13,065	653	20	653		4,545	19
20	Villa Architects		2002		17,574	879	20	879		5,713	20
21	Bilding Siding		2002		150,792	7,540	20	7,540		49,010	21
22	Architects Studies		2002		18,109	905	20	905		5,883	22
23	Cabinets		2002		448	22	20	22		143	23
24	Food Service Equipment		2002		512	26	20	26		169	24
25	Facilities Management		2003		27,833	2,783	10	2,783		15,307	25
26	Cabling, Cameras, Sound System		2003		5,490	549	10	549		3,020	26
27	Decorating		2003		20,475	2,048	10	2,048		11,264	27
28	Fire Alarm Systems		2003		12,565	1,257	10	1,257		6,913	28
29	Cabinets		2003		36,787	1,839	20	1,839		10,115	29
30	Electrical Wiring		2003		42,505	2,125	20	2,125		11,688	30
31	Heating & Ventilation		2003		90,418	4,521	20	4,521		24,865	31
32	Architects Studies		2003		52,552	2,628	20	2,628		14,454	32
33	Asbestos Removal		2003		7,050	353	20	353		1,941	33
34	Architects Studies		2003		120,149	6,007	20	6,007		33,039	34
35	Medicare Wing Construction		2003		26,056	744	35	744		2,604	35
36	Payments to Advocate		2003		224,609	6,417	35	6,417		35,294	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:

04/01/2007 Ending: 03/31/2008

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		\$ 9,442	\$	\$ 30,685	37
38	Payments to Advocate	2004	321,482	9,185		9,185		32,149	38
39	Siding	2004	5,914	296		296		1,036	39
40	Roof	2004	18,632	932		932		3,262	40
41	Facilities Management	2004	67,311	3,366		3,366		11,778	41
42	Plumbing	2004	47,360	2,368		2,368		8,288	42
43	Flooring/carpeting	2004	23,097	1,155		1,155		4,041	43
44	Construction/Renovation-Demolition,Coring	2004	162,145	3,243		3,243		11,349	44
45	Asbestos Removal	2004	8,522	426		426		1,491	45
46	Architects Services	2004	60,429	3,021		3,021		10,575	46
47	Electrical upgrades	2004	8,817	441		441		1,542	47
48	Heating and Ventilation	2004	16,000	800		800		2,800	48
49	Architects Services	2004	161,357	4,610		4,610		16,135	49
50	Construction/Renovation-Electrical, Fire Protection	2004	1,472,060	22,341		22,341		74,461	50
51	Architects Services	2004	9,278	464		464		1,624	51
52	Roof	2004	7,723	386		386		1,351	52
53	Plumbing	2004	10,757	538		538		1,655	53
54	Construction/Renovation-All Channeling	2004	135,355	2,707		2,707		6,221	54
55	Cabinest	2004	10,479	524		524		1,834	55
56	MC Wing Renovation	2004	7,379	738		738		2,583	56
57	Payments to Advocate	2005	303,421	8,669		8,669		69,353	57
58	Faciliteis Management	2005	78,442	7,844		7,844		23,532	58
59	Roof	2005	29,520	2,952		2,952		8,856	59
60	Construction/Renovation-Ceramic tile, Painting	2005	98,907	9,891		9,891		29,672	60
61	Architects Services	2005	6,367	637		637		1,910	61
62	Asbestos Removal	2005	3,439	344		344		1,032	62
63	Construction/Renovation-Storm Sewer, Plumbing	2005	138,844	13,884		13,884		41,652	63
64	Consturction New Villas	2005	1,170,207	23,404		23,404		257,445	64
65	Architects Services	2005	24,566	2,457		2,457		7,370	65
66	Construction/Renovation-Carpentry, Electrical	2005	236,197	11,810		11,810		37,490	66
67	HCC Renovation Project Demolition, Carpentry	2006	414,807	20,740		20,740		62,220	67
68	Electrical, Fire Protection, Communication	2006	249,586	7,131		7,131		31,807	68
69	Plumbing	2006	84,373	4,219		4,219		12,657	69
70	TOTAL (lines 4 thru 69)		\$ 12,667,074	\$ 478,347		\$ 478,347	\$ (2,420,590)	\$ 2,382,564	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:

04/01/2007 Ending: 03/31/2008

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		\$ 12,667,074	\$ 478,347		\$ 478,347	\$	\$ 2,382,564	1
2	Flooring/Drywall/Doors/Painting	2006	244,473	2,224	20	2,224		36,672	2
3	Architect Services	2006	107,786	5,389	20	5,389		16,167	3
4	Hating/AC	2006	91,699	4,585	20	4,585		13,755	4
5	Room Finish Work aAppliances/Beds/Furniture/Windows	2006	168,231	6,823	10	6,823		50,469	5
6	Payments to Advocate-Audit	2007	(90,953)	(1,299)	35	(1,299)			6
7	Architect Services	2007	715	36	10	36		72	7
8	Architect Services	2007	11,504	288	20	288		576	8
9	Construction/Renovation Residents Cottages	2007	24,604	351	35	351		702	9
10	Facilities Management	2007	53,271	1,332	20	1,332		3,996	10
11	Mis-rise Roof Replacement	2007	68,762	1,719	20	1,719		5,157	11
12	Roof Replacement	2007	3,322	47	35	47		94	12
13	Renovation Ind Health Care Apts	2007	36,060	902	20	902		1,804	13
14	Renovation Kitchen/Dining Services	2007	25,072	1,254	10	1,254		2,508	14
15	Renovation Sheltered Care Windows	2007	7,003	350	10	350		700	15
16	Renovation/Construction Medicare Wing	2007	35,818	1,791	10	1,791		3,582	16
17	Renovation/construction Sheltered Care	2007	219,800	5,495	20	5,495		16,485	17
18	Construction/Renovation-Villas	2007	6,772	68	50	68		136	18
19	Facilities Management	2008	8,340	417	20	417		1,438	19
20	Roads and Sewers	2008	48,057	480	50	480		3,314	20
21	Renovation Sheltered Care Windows, wiring	2008	47,714	2,386	10	2,386		16,547	21
22	Payments/Settlement to Advocate	2008							22
23	Facilities management	2008	30,756	769	20	769		5,303	23
24	Renovation Ind/Flooring/finishwork/appliances	2008	43,206	2,160	10	2,160		14,899	24
25	Roofing/Paving	2008	96,725	1,382	35	1,382		9,529	25
26	Architect Services	2008	2,220	56	20	56		383	26
27	Architect Services	2008	9,823	246	20	246		1,694	27
28	Renovation improvements	2008	85,872	2,147	20	2,147		14,806	28
29	Engineering/elevator	2008	5,563	139	20	139		959	29
30	Facilities Management	2008	8,488	212	20	212		1,463	30
31	Renovation/Construction Healthcare/Medicare Wing	2008	69,394	3,470	10	3,470		24,306	31
32	Renovation Sheltered Care/Mechanical/finishwork	2008	19,235	6,633	10	6,633		6,633	32
33	Renovation/Construction Healthcare/Medicare Wing	2008	126,452	7,299	10	7,299		6,323	33
34	TOTAL (lines 1 thru 33)		\$ 14,282,858	\$ 537,498		\$ 537,498	\$	\$ 2,643,036	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	\$ 1,248,833	\$ 91,889	\$ 91,889	\$		\$ 726,920	71
72	Current Year Purchases	16,812						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,265,645	\$ 91,889	\$ 91,889	\$		\$ 726,920	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	\$ 22,104	\$ 28,030	\$ 28,030	\$		\$ 117,320	76
77	Bus		2005	94,681						77
78	Van		2006	16,885						78
79										79
80	TOTALS			\$ 133,670	\$ 28,030	\$ 28,030	\$		\$ 117,320	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)		\$ 16,427,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 657,417	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 657,417	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)		\$ 3,487,276	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	land	\$ 1,828,723	\$	\$	86
87	building	34,968,376	1,249,323	6,470,880	87
88	equipment	3,425,907	398,861	2,066,932	88
89					89
90					90
91	TOTALS	\$ 40,223,006	\$ 1,648,184	\$ 8,537,812	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

* 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>65</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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		2,818		2,818
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		79,583		79,583
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 82,401	\$	\$ 82,401
10	SUM OF line 9, col. 1 and 2 (e)	\$	82,401		

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"/>
TOTAL TRAINED	<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 prescripts				429,181		429,181	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 429,181		\$ 429,181	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: 04/01/2007

Ending:

03/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 03/31/2008

(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)	1,203,789		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	477,806		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,682,595	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,574,033		13
14	Buildings, at Historical Cost	49,251,235		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,825,222		16
17	Accumulated Depreciation (book methods)	(12,025,088)		17
18	Deferred Charges	114,147		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):	(584,431)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 44,155,118	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 45,837,713	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,401,516	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	469,272		28
29	Short-Term Notes Payable			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)	\$ 5,870,788	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	103,789		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Revenue	42,261,862		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 42,365,651	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,236,439	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,398,726)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 45,837,713	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,894,124)	1
2	Restatements (describe):		2
3	audit adj	(240,346)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,134,470)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(264,256)	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)	\$ (264,256)	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)	\$ (2,398,726)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number THE MOORINGS HEALTH CENTER# 0045047Report Period Beginning: 04/01/2007Ending: 03/31/2008**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	\$ 21,449,786	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,449,786	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(43,148)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (43,148)	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)	\$ 21,406,638	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	6,331,312	31
32	Health Care	6,888,075	32
33	General Administration	5,820,341	33
B. Capital Expense			
34	Ownership	2,555,450	34
C. Ancillary Expense			
35	Special Cost Centers	716	35
36	Provider Participation Fee	75,000	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 21,670,894	40
41	Income before Income Taxes (line 30 minus line 40)**	(264,256)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (264,256)	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: **04/01/2007**

Ending:

03/31/2008

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	1,742	1,985	\$ 81,913	\$ 41.27	1
2	Assistant Director of Nursing	3,739	4,072	152,823	37.53	2
3	Registered Nurses	39,909	43,450	1,406,739	32.38	3
4	Licensed Practical Nurses	16,831	18,241	349,709	19.17	4
5	CNAs & Orderlies	139,560	152,008	2,305,219	15.17	5
6	CNA Trainees					6
7	Licensed Therapist	9,972	10,464	367,325	35.10	7
8	Rehab/Therapy Aides	5,513	6,441	117,950	18.31	8
9	Activity Director	3,895	4,406	104,725	23.77	9
10	Activity Assistants	15,066	16,528	225,407	13.64	10
11	Social Service Workers	3,563	4,151	94,106	22.67	11
12	Dietician					12
13	Food Service Supervisor	7,011	8,042	107,633	13.38	13
14	Head Cook	13,023	14,738	222,485	15.10	14
15	Cook Helpers/Assistants	72,344	77,392	669,536	8.65	15
16	Dishwashers	5,034	5,401	49,104	9.09	16
17	Maintenance Workers	31,654	35,504	702,619	19.79	17
18	Housekeepers	60,575	67,534	679,968	10.07	18
19	Laundry					19
20	Administrator	1,750	2,356	214,767	91.16	20
21	Assistant Administrator					21
22	Other Administrative	10,119	10,119	404,784	40.00	22
23	Office Manager					23
24	Clerical	13,033	14,788	273,621	18.50	24
25	Vocational Instruction	2,932	2,932	79,583	27.14	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	1,426	1,563	24,338	15.57	31
32	Other Health Care(specify)					32
33	Other(specify)	28,145	31,088	573,929	18.46	33
34	TOTAL (lines 1 - 33)	486,836	533,203	\$ 9,208,283 *	\$ 17.27	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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,991	\$ 279,378	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,991	\$ 279,378		53

Facility Name & ID Number THE MOORINGS HEALTH CENTER

Report Period Beginning: 04/01/2007 Ending: 03/31/2008

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	HEATING & VENTILAT	3/2003	\$ 43,053	5	\$ 8,611	\$ 8,610	\$ 8,610	\$ 4,305	\$	\$	\$	\$	\$
2	A/C & HEATING	3/2004	44,900	5	8,980	8,980	8,980	8,980	4,490				
3	BOILER	3/2005	9,774	3	1,629	3,258	3,258	1,629					
4	HEATING & VENTILAT	3/2005	30,680	5	3,068	6,136	6,136	6,136	6,136	3,068			
5	ELEVATORS	3/2005	18,650	3	3,108	6,217	6,217	3,108					
6	A/C & HEATING	3/2005	11,631	3	1,939	3,877	3,877	1,938					
7	ELEVATORS	3/2006	18,224	3		3,037	6,075	6,075	3,037				
8	HEATING & VENTILAT	3/2006	33,712	5		3,371	6,742	6,742	6,742	6,742	3,373		
9	A/C & HEATING	3/2006	28,930	3		4,822	9,643	9,643	4,822				
10	ELEVATORS	3/2007	19,989	3			3,332	6,663	6,663	3,331			
11	ROOF MAINTENANCE	3/2007	30,232	5			3,024	6,046	6,046	6,046	6,046	3,024	
12	A/C & HEATING	3/2007	47,782	3			7,964	15,927	15,927	7,964			
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 337,557		\$ 27,335	\$ 48,308	\$ 73,858	\$ 77,192	\$ 53,863	\$ 27,151	\$ 9,419	\$ 3,024	\$

Facility Name & 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,927 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. \$ 59,410 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? _____
- 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.