FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 (Number) Arlington Hgts (City) 60005 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deb Freeland **Telephone Number:** 317-569-6230
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/2014 to 3/31/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Deb Freeland, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen, LLP, 9365 Counselor's Row, Suite 200, Indianapolis, IN 46240
(Telephone) (314) 925-4300 Fax # (314) 925-4350

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: 4/1/2014 Ending: 3/31/15

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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	44	Sheltered Care (SC)	44	16,060	5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	360	15,233	8,191	23,784	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	110	7,898		8,008	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	470	23,131	8,191	31,792	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.44%

D. How many bed-hold days during this year were paid by the Department?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 10/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 8,191

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 03/31/2015 Fiscal Year: 03/31/2015

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

Facility Name & ID Number The Moorings Health Center # 0045047 **Report Period Beginning:** 4/1/2014 **Ending:** 3/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	702,675	76,596	19,603	798,874		798,874		798,874			1
2	Food Purchase		568,391		568,391		568,391	(12,419)	555,972			2
3	Housekeeping	204,769	24,589	10,038	239,396		239,396	(60)	239,336			3
4	Laundry	45,803	21,543	1,360	68,706		68,706		68,706			4
5	Heat and Other Utilities			226,298	226,298		226,298		226,298			5
6	Maintenance	170,985	24,229	112,700	307,914		307,914		307,914			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,124,232	715,348	369,999	2,209,579		2,209,579	(12,479)	2,197,100			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,547,292	343,252	16,780	4,907,324		4,907,324		4,907,324			10
10a	Therapy											10a
11	Activities	132,850	6,129	24,501	163,480		163,480		163,480			11
12	Social Services	98,826	180	876	99,882		99,882		99,882			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,778,968	349,561	42,157	5,170,686		5,170,686		5,170,686			16
	C. General Administration											
17	Administrative	56,617		61,476	118,093		118,093		118,093			17
18	Directors Fees											18
19	Professional Services			60,232	60,232		60,232		60,232			19
20	Dues, Fees, Subscriptions & Promotions			15,237	15,237		15,237		15,237			20
21	Clerical & General Office Expenses	57,859	6,547	803,228	867,634		867,634	(925)	866,709			21
22	Employee Benefits & Payroll Taxes			1,681,060	1,681,060		1,681,060		1,681,060			22
23	Inservice Training & Education											23
24	Travel and Seminar			33,534	33,534		33,534		33,534			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,718	49,718		49,718		49,718			26
27	Other (specify):* **Marketing**		757	25,730	26,487		26,487	(26,487)				27
28	**TOTAL General Administration**	114,476	7,304	2,730,215	2,851,995		2,851,995	(27,412)	2,824,583			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,017,676	1,072,213	3,142,371	10,232,260		10,232,260	(39,891)	10,192,369			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: 4/1/2014 Ending: 3/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			291,861	291,861		291,861		291,861			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			291,861	291,861		291,861		291,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	871,138	277,712	114,226	1,263,076		1,263,076		1,263,076			39
40	Barber and Beauty Shops		1,241	38,373	39,614		39,614		39,614			40
41	Coffee and Gift Shops		3,785		3,785		3,785		3,785			41
42	Provider Participation Fee			205,476	205,476		205,476		205,476			42
43	Other (specify):* AL/IL	3,975,302	287,214	8,718,518	12,981,034		12,981,034	(12,981,034)				43
44	**TOTAL Special Cost Centers**	4,846,440	569,952	9,076,593	14,492,985		14,492,985	(12,981,034)	1,511,951			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,864,116	1,642,165	12,510,825	25,017,106		25,017,106	(13,020,925)	11,996,181			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: 4/1/2014 Ending: 3/31/15

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,419)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(60)	03		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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				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	(925)	21		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 page 5A	(13,007,521)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (13,020,925)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (13,020,925)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

The Moorings Health Center

ID# **0045047**

Report Period Beginning: **4/1/2014**

Ending: **3/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL Salaries	$ (3,975,302)	43	1
2	AL/IL Supplies	(287,214)	43	2
3	AL/IL Other Expenses	(8,718,518)	43	3
4	Marketing Supplies	(757)	27	4
5	Marketing Other Expenses	(25,730)	27	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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**	(13,007,521)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Moorings Health Center **#** 0045047 **Report Period Beginning:** 4/1/2014 **Ending:** 3/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,419)	0	0	0	0	0	0	0	0	0	0	(12,419)	2
3	Housekeeping	(60)	0	0	0	0	0	0	0	0	0	0	(60)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,479)	0	0	0	0	0	0	0	0	0	0	(12,479)	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	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(925)	0	0	0	0	0	0	0	0	0	0	(925)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(26,487)	0	0	0	0	0	0	0	0	0	0	(26,487)	27
28	**TOTAL General Administration**	(27,412)	0	0	0	0	0	0	0	0	0	0	(27,412)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,891)	0	0	0	0	0	0	0	0	0	0	(39,891)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Moorings Health Center **#** 0045047 **Report Period Beginning:** 4/1/2014 **Ending:** 3/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(12,981,034)	0	0	0	0	0	0	0	0	0	0	(12,981,034)	43
44	**TOTAL Special Cost Centers**	(12,981,034)	0	0	0	0	0	0	0	0	0	0	(12,981,034)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,020,925)	0	0	0	0	0	0	0	0	0	0	(13,020,925)	45

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached listing		McGraw Care Center	Evanston			
		Balmoral Care Center	Lake Forest			
		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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Management Fee	$ 760,782	Presbyterian Homes Corporate	0.00%	$ 760,782	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 760,782			$ 760,782	$ *	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: 4/1/2014 Ending: 3/31/15

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: 4/1/2014 Ending: 3/31/15

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 Debra O'Neill

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-10-113-004-0000	811 E. Central Rd Arlington Heights	$ 104,159.00	$
2.	08-10-113-003-0000	800 E. Central Rd Arlington Heights	$ 68,230.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 172,389.00	$

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 and 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 4/1/2014 Ending: 3/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,857 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (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 Unites, square footage 325,616.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	160		2000		$ 1,448,372	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2001	2,796		20				9
10	Emergency Power Connections Shelter Care			2009	19,135		20				10
11	Shelter Care unit Renov. (Wiring, lightFixtures, Toilets, Sinks)			2009	59,926		20				11
12	Emergency Power Connections Health Care			2009	27,393		20				12
13	Renov. Of HCC Lobby and Resident Corridors Flooring, Windows			2009	130,000		20				13
14	HCC Roof Replacement			2009	187,270		20				14
15	Door System			2010	4,345		20				15
16	Door System			2010	4,668		20				16
17	Walkway: Threshold At Main Entrance			2010	5,729		20				17
18	HVAC Services			2010	3,854		20				18
19	Demolition, Carpentry, Framing, Floors, Plumbing, Electrical			2010	30,259		20				19
20	Architect Fees (Rooms 107 & 119)			2010	5,317		20				20
21	Resident Cooridor Painting			2010	3,700		20				21
22	Architect Fees (Hallway & Lobby)			2010	17,437		20				22
23	Cooridor Carpeting			2010	35,782		20				23
24	Electrical - Pipe, Wire, Junction Boxes, Fixtures			2010	69,500		20				24
25	Cooridor Carpentry			2010	35,000		20				25
26	Cooridor Painting			2010	28,700		20				26
27	New Condensing Unit With Evaporator			2010	3,598		20				27
28	Physicail Therapy Office - New Condensing Unit			2010	2,743		20				28
29	Moorings Masonry			2011	19,000		20				29
30	Install New Health Center Back-Up Pumps For Heating			2012	34,285		20				30
31	Mid-Rise Domestic Hot Water Heater Replacement			2012	159,722		20				31
32	Replace Health Center Hot Water Mixing Value			2012	8,571		20				32
33	Contingency HC Water Heater			2012	7,387		20				33
34	Standard Pipe & Supply			2012	7,952		20				34
35	Replace floor in room 761			2012	1,200		20				35
36	Evaluate soil conditions			2012	1,396		20				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: 4/1/2014 Ending: 3/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remove/replace concrete slabs inside Janitor's closet - HC Building	2012	$ 49,645	$	20	$	$	$	37
38	Replace windows and re-paint Marketing Office 1st floor - HC Bui	2013	2,547		20				38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			223,594		223,594		996,247	69
70	TOTAL (lines 4 thru 69)		$ 2,417,229	$ 223,594		$ 223,594	$	$ 996,247	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: 4/1/2014 Ending: 3/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 681,798	$	$	$	Various	$	71
72	Current Year Purchases	78,880				Various		72
73	Fully Depreciated Assets							73
74	Equipment Depreciation		68,267	68,267			548,294	74
75	TOTALS	$ 760,678	$ 68,267	$ 68,267	$		$ 548,294	75

D. Vehicle Costs. (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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,177,907	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 291,861	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 291,861	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)	$ 1,544,541	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	AL	$ 4,893,622	$ 232,950	$ 3,523,699	86
87	IL	75,831,511	3,474,052	28,466,201	87
88					88
89					89
90					90
91	TOTALS	$ 80,725,133	$ 3,707,002	$ 31,989,900	91

G. Construction-in-Progress

	Description	Cost	
92	Corp Allocation	$ 463,788	92
93			93
94			94
95		$ 463,788	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: 4/1/2014 Ending: 3/31/15

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

(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.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-01	6241 hrs	$ 202,739	353	$ 23,033	$	6,594	$ 225,772	1
2	Licensed Speech and Language Development Therapist	39-01	4035 hrs	143,730	47	2,740		4,082	146,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	14139 hrs	524,669	6	314		14,145	524,983	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				272,567		272,567	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Mgmt Fees	39-03				60,000			60,000	12
13	Other (specify):									13
14	TOTAL			$ 871,138	406	$ 86,087	$ 272,567	24,821	$ 1,229,792	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.

STATE OF ILLINOIS

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 3/31/15 (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	$ 10,694,285	$	1
2	Cash-Patient Deposits	1,825,011		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,796,338		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,631,354		5
6	Prepaid Insurance	1,115,274		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,353,505		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 20,415,767	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	121,908,810		12
13	Land	32,467,295		13
14	Buildings, at Historical Cost	395,508,411		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,358,097		16
17	Accumulated Depreciation (book methods)	(210,015,786)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe**Attached**	6,439,690		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 397,666,517	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 418,082,284	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,865,435	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,935,000		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	383,647		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Attached**	7,999,723		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 25,183,805	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	61,600,000		39
40	Mortgage Payable			40
41	Bonds Payable	42,815,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**LT Portion of Min Pension Liab**	10,145,847		43
44	**Other Non-Current Liab**	244,023,144		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 358,583,991	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 383,767,796	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 34,314,488	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 418,082,284	$	48

*(See instructions.)

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 4/1/2014 Ending: 3/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 178,373,547	1	
2	Restatements (describe):		2	
3	**Net Income Reconciliation to Consolidated Balance Sheet**	(146,063,616)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,309,931	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,004,557	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)**	$ 2,004,557	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)**	$ 34,314,488	24	*

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,469,019	1
2	Discounts and Allowances for all Levels	(611,950)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,857,069	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,620,418	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,620,418	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	64,837	12
13	Barber and Beauty Care	136,339	13
14	Non-Patient Meals	2,551	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	133,144	16
17	Sale of Drugs	262,050	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,548	19
20	Radiology and X-Ray	41,728	20
21	Other Medical Services	96,863	21
22	Laundry	60	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 745,120	23
	D. Non-Operating Revenue		
24	Contributions	291,095	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 291,095	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AI/IL	15,401,159	28
28a	Miscellaneous	106,802	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,507,961	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 27,021,663	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,209,579	31
32	Health Care	5,170,686	32
33	General Administration	2,851,995	33
	B. Capital Expense		
34	Ownership	291,861	34
	C. Ancillary Expense		
35	Special Cost Centers	1,306,475	35
36	Provider Participation Fee	205,476	36
	D. Other Expenses (specify):		
37	AL/IL	12,981,034	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 25,017,106	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,004,557	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,004,557	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 57,283	44
45	Private Pay - Net Inpatient Revenue	6,672,650	45
46	Medicare - Net Inpatient Revenue	2,280,149	46
47	Other-(specify) Charity care	(153,013)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,857,069	49

* **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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,789	1,950	$ 104,344	$ 53.51	1
2	Assistant Director of Nursing	1,723	1,950	100,450	51.51	2
3	Registered Nurses	175,764	190,595	2,079,790	10.91	3
4	Licensed Practical Nurses	6,093	6,575	128,036	19.47	4
5	CNAs & Orderlies	212,648	233,038	1,938,244	8.32	5
6	CNA Trainees					6
7	Licensed Therapist	22,080	24,273	867,979	35.76	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	19,106	20,978	376,268	17.94	10
11	Social Service Workers	5,912	6,917	194,700	28.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	92,129	99,407	1,544,594	15.54	15
16	Dishwashers					16
17	Maintenance Workers	48,930	54,005	1,077,966	19.96	17
18	Housekeepers	47,742	52,697	620,011	11.77	18
19	Laundry	7,485	8,088	79,508	9.83	19
20	Administrator	1,826	2,025	129,715	64.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,065	29,578	943,295	31.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,934	4,381	143,796	32.82	31
32	Other Health C: MDS/Rehab/Pasto	24,903	27,741	535,420	19.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	699,129	764,198	$ 10,864,116 *	$ 14.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	29	611	10-03	52
53	TOTAL (lines 50 - 52)	29	$ 611		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Benni	Executive Director		$ 56,617
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,617

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R Healthcare Consulting	Legal	$ 250
CliftonLarsonAllen	Audit	821
AV Powell & Associates	Actuarial	2,400
Various	Activities	38,373
Shaker Recruitment	Recruiting	7,934
Malecki, Tasch & Burns	Risk Management	3,823
Various	Marketing	6,015
Various	Inspectoins	616
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 60,232

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,140
Unemployment Compensation Insurance	
FICA Taxes	500,831
Employee Health Insurance	870,183
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,040
Retirement	235,179
Long-Term Disability	23,687
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,681,060

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	6,339
Licenses	8,359
Recruiting	539
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,237

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	809
Seminar Expense	32,725
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33,534

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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. **No**

(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. $ **38,987** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **205,476**
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. $ _____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12,419**

(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? **None**
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? **Yes**
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: **CliftonLarsonAllen LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.