FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0053967

Facility Name: Moorings of Arlington Hghts

Address: 761 Old Barn Lane (Number) Arlington Heights (City) 60005 (Zip Code)

County: Cook

Telephone Number: 847-956-4500 Fax # 847-956-4451

HFS ID Number:

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

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: Joshua S. Banach Telephone Number: (847) 628-8784
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 4/1/19 to 3/31/20 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) CFO
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title) Denise A. Leonard, CPA Partner
	(Firm Name & Address) Plante Moran, PLLC 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
	(Telephone) (216) 274-6514 Fax # (248) 233-7349

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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	84	Skilled (SNF)	84	30,744	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	11,712	3
4		Intermediate/DD			4
5	44	Sheltered Care (SC)	44	16,104	5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,560	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	906	9,509	6,951	17,366	8
9	SNF/PED					9
10	ICF		7,239		7,239	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	906	16,748	6,951	24,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.02%

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

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

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

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

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 10/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 5,650

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: 3/31/2020 Fiscal Year: 3/31/2020

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 **Report Period Beginning:** 4/1/19 **Ending:** 3/31/20

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	427,167	30,771	94,720	552,658		552,658		552,658			1
2	Food Purchase		215,348		215,348		215,348		215,348			2
3	Housekeeping	157,756	31,425	16,861	206,042		206,042		206,042			3
4	Laundry	59,671	36,118	2,583	98,372		98,372		98,372			4
5	Heat and Other Utilities			158,128	158,128		158,128		158,128			5
6	Maintenance	125,482	150,351	14,712	290,545		290,545		290,545			6
7	Other (specify):*											7
8	**TOTAL General Services**	770,076	464,013	287,004	1,521,093		1,521,093		1,521,093			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	3,885,626	287,471	432,642	4,605,739		4,605,739		4,605,739			10
10a	Therapy		1,844	913,636	915,480		915,480		915,480			10a
11	Activities	205,090	3,572	8,440	217,102		217,102		217,102			11
12	Social Services	136,315	126	176	136,617		136,617		136,617			12
13	CNA Training											13
14	Program Transportation			2,251	2,251		2,251		2,251			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,227,031	293,013	1,396,145	5,916,189		5,916,189		5,916,189			16
	C. General Administration											
17	Administrative	163,805		850,605	1,014,410		1,014,410	(134,429)	879,981			17
18	Directors Fees											18
19	Professional Services			151,326	151,326		151,326		151,326			19
20	Dues, Fees, Subscriptions & Promotions			23,134	23,134		23,134		23,134			20
21	Clerical & General Office Expenses	368,426	18,092	312,443	698,961		698,961	(221,941)	477,020			21
22	Employee Benefits & Payroll Taxes			1,892,615	1,892,615		1,892,615		1,892,615			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,461	2,461		2,461		2,461			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			317,271	317,271		317,271		317,271			26
27	Other (specify):* Mktg/Advertising			40,091	40,091		40,091	(40,091)				27
28	**TOTAL General Administration**	532,231	18,092	3,589,946	4,140,269		4,140,269	(396,461)	3,743,808			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,529,338	775,118	5,273,095	11,577,551		11,577,551	(396,461)	11,181,090			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 Moorings of Arlington Hghts #0053967 **Report Period Beginning:** 4/1/19 **Ending:** 3/31/20

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			850,273	850,273		850,273	(195,808)	654,465			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			149,092	149,092		149,092		149,092			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,883	22,883		22,883		22,883			35
36	Other (specify):* Taxes/HO Cap			63,094	63,094		63,094	(2,776)	60,318			36
37	TOTAL Ownership			1,085,342	1,085,342		1,085,342	(198,584)	886,758			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,129	179,129		179,129		179,129			42
43	Other (specify):* Clinic	329			329		329	(329)				43
44	TOTAL Special Cost Centers	329		179,129	179,458		179,458	(329)	179,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,529,667	775,118	6,537,566	12,842,351		12,842,351	(595,374)	12,246,977			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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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				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				8
9	Non-Straightline Depreciation	(195,808)	30		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	(63,094)	36		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	(43,243)	21		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	(178,657)	21		24
25	Fund Raising, Advertising and Promotional	(40,091)	27		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	(370)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (521,263)		$	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 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)	(74,111)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,111)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (595,374)		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

BHF USE ONLY

48		49		50		51		52	

Moorings of Arlington Hghts

ID# 0053967

Report Period Beginning: 4/1/19

Ending: 3/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Cllinic Salaries	$ (329)	43	1
2	Community Engagement	(41)	21	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				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**	(370)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	(134,429)	0	0	0	0	0	0	0	0	0	(134,429)	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	(221,941)	0	0	0	0	0	0	0	0	0	0	(221,941)	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):*	(40,091)	0	0	0	0	0	0	0	0	0	0	(40,091)	27
28	**TOTAL General Administration**	(262,032)	(134,429)	0	0	0	0	0	0	0	0	0	(396,461)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(262,032)	(134,429)	0	0	0	0	0	0	0	0	0	(396,461)	29

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(195,808)	0	0	0	0	0	0	0	0	0	0	(195,808)	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):*	(63,094)	60,318	0	0	0	0	0	0	0	0	0	(2,776)	36
37	TOTAL Ownership	(258,902)	60,318	0	0	0	0	0	0	0	0	0	(198,584)	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):*	(329)	0	0	0	0	0	0	0	0	0	0	(329)	43
44	TOTAL Special Cost Centers	(329)	0	0	0	0	0	0	0	0	0	0	(329)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(521,263)	(74,111)	0	0	0	0	0	0	0	0	0	(595,374)	45

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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
Presbyterian Homes	100%	Balmoral Care Center (Lake Forest Place)	Lake Forest, IL	Presbyterian Homes Manager	Evanston, IL	Management
		McGaw Care Center (Westminster Place)	Evanston, IL	Presbyterian Homes Outpatient	Evanston, IL	Outpatient Therapy
				Rehab Agency, LLC		
				Ten Twenty Grove, LLC	Evanston, IL	Senior Ind Living

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	17	Home Office A&G	$ 850,605	Presbyterian Homes Manager	100.00%	$ 716,176	$ (134,429)	1
2	V	36	Home Office Capital		Presbyterian Homes Manager		60,318	60,318	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			$ 850,605			$ 776,494	$ * (74,111)	14

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Board of Directors								$		1
2	Paula Noble	Board Chair									2
3	Michael Kirby	Secretary									3
4	Neele Stearns	Treasurer									4
5	Terri Brady	Director									5
6	Charlie Denison	Director									6
7	David Donnersberger	Director									7
8	Monica Heenan	Director									8
9	Elinor Hite	Director									9
10	Lee Hutchinson	Director									10
11	Vince Kelly	Director									11
12	See Supplemental Page 7										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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Thomas McAfee	Director							$		1
2	Dennis Marx	Director									2
3	Marshall Peck	Director									3
4	Mark Toledo	Director									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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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]

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

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

	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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

	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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

	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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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							$	$			$	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	Presbyterian Home Manager	X		To Terminate Defined		2/8/2018	902,500		2/1/2020	3.4370	3,069	10
11	Offset by Interest Income			Benefit Plan							(3,069)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 902,500	$			$	14
15	TOTALS (line 9+line14)						$ 902,500	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* 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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	15,620	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.)	$	15,620	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	149,092	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.	$	149,092	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015		8
2016		9
2017		10
2018		11
2019	15,620	12

Beginning accrual adjusted to account for initial RE tax year

2020 Accrual: $142,004 x 9.55 (estimated tax impact due to increase in assessed value) x 11% (allocated to H/C)

Accrual reported above on line 4 reflects the accrual applicable to the nursing home real estate taxes only

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Moorings of Arlington Hghts COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0053967

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	08-10-113-002-0000	811 E CENTRAL RD	$	$
2.	08-10-113-003-0000	811 E CENTRAL RD	$ 38,533.14	$ 4,238.65
3.	08-10-113-004-0000	811 E CENTRAL RD	$ 103,470.66	$ 11,381.77
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 142,003.80	$ 15,620.42

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? X YES ____ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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. [X] (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).

Independent Living facility in the Moorings of Arlington Heights contains 199 apartments and 72 villas. Total square forage is 505,692.
Assisted Living facility in the Moorings of Arlington Heights contains 73 apartments. Total square footage is 120,884.
Assisted Living Memory Support facility in the Moorings of Arlington Heights contains 20 private rooms. Total square footage is 29,398.

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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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											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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

XI. OWNERSHIP COSTS (continued)

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

	1	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	Evaluate soil conditions	2012	$ 1,396	$	20	$	$	$	37
38	Remove concrete slabs and replace with new slabs	2012	49,645		20				38
39	Nursing Facility Allocation of Window Improvements	2013	2,547		20				39
40	Nursing Facility Allocation of Bldg Improvements	2014	76,064		20				40
41	New pit ladders in elevator cars	2015	4,954		10				41
42	Sewer ejector pumps replacement	2015	7,170		10				42
43	Steel exterior fire door replacement	2015	9,927		10				43
44	Operator and release device on the roll up fire door	2015	4,875		10				44
45	Health Center shower rooms renovation - wall tile replacement	2015	31,457		10				45
46	Floor replacement - first floor health center	2016	17,432		10				46
47	Patient room renovation - furniture replacement, painting, drapers.	2016	261,513		10				47
48	Storm Lift Station submersible pumps replacement	2017	7,120		20				48
49	Return plumbing main replacement	2017	18,675		20				49
50	Compressor replacement in healthcare	2017	8,199		20				50
51	Entrance canopy repair and recoat paint outside healthcare entranc	2017	5,620		10				51
52	Activities lockers building construction and renovation	2017	273,480		10				52
53	Activities lockers painting	2017	4,360		10				53
54	Activities lockers flooring replacement	2017	18,652		5				54
55	Rehab renovation - Fees/preconstruction services/ concrete/ demolit	2017	122,620		10				55
56	Rehab renovation - General conditions	2017	117,046		10				56
57	Rehab renovation - HVAC air distribution and equipment	2017	110,957		10				57
58	Rehab renovation - Electrical	2017	80,564		10				58
59	Rehab renovation - Carpentry	2017	62,975		10				59
60	Rehab renovation - Doors and frames	2017	46,225		10				60
61	Rehab renovation - Woodwork	2017	42,662		10				61
62	Rehab renovation - Plumbing	2017	22,285		10				62
63	Rehab renovation - Wall replacement and painting	2017	10,510		10				63
64	Rehab renovation - Floor replacement	2017	53,479		5				64
65	Laundry room cooling unit replacement	2018	44,600		10				65
66	Dryvit surfaces on HC building	2018	12,335		10				66
67	Healthcare Center 1st&2nd floor dining area architectural woodwo	2019	391,145		20				67
68	Healthcare Center 1st&2nd floor dining area painting and wall cove	2019	25,266		10				68
69	Healthcare Center 1st&2nd floor dining area flooring and window t	2019	246,746		5				69
70	TOTAL (lines 4 thru 69)		$ 4,556,141	$		$	$	$	70

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12A, Carried Forward		$ 4,556,141	$		$	$	$	1
2	Healthcare Center lobby and therapy space landscaping	2019	151,443		25				2
3	Healthcare Center lobby and therapy space painting and wall cover	2019	1,392,549		10				3
4	Healthcare Center lobby and therapy space flooring and window tr	2019	107,780		5				4
5	HC Center 1st&2nd fl dining area architectural woodwork, genenr	2019	12,335		10				5
6	Dryvit surfaces on Healthcare Center building	2019	3,927		20				6
7									7
8									8
9	Financial Statement Depreciation			433,418		433,418		3,116,674	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12B, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12C, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12D, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12E, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12F, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12G, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	
1	Totals from Page 12H, Carried Forward		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	1
2									2
3									3
4									4
5									5
6									6
7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,224,175	$ 433,418		$ 433,418	$	$ 3,116,674	34

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	$ 2,206,786	$	$	$		$ 819,599	71
72	Current Year Purchases	130,281						72
73	Fully Depreciated Assets							73
74	Financial Statement Depreciation		221,047	221,047			221,047	74
75	TOTALS	$ 2,337,067	$ 221,047	$ 221,047	$		$ 1,040,646	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)	$ 8,561,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 654,465	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 654,465	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)	$ 4,157,320	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	Assisted Living	$ 67,518,951	$ 2,869,303	$ 5,593,303	86
87	Independent Living	110,687,487	6,008,257	52,204,110	87
88					88
89					89
90					90
91	TOTALS	$ 178,206,438	$ 8,877,560	$ 57,797,413	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 81,825	92
93			93
94			94
95		$ 81,825	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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 22,883 Description: Dish Machine $3,390; Chairs $4,706; Postage Meter $2,233; Fingerprinter $1,664; Printer/Copier $10,890
    (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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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.

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	V10A	hrs	$	15,353	$ 309,417	$ 633	15,353	$ 310,050	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		3,075	103,777	217	3,075	103,994	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		27,770	500,442	994	27,770	501,436	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	V39								12
13	Other (specify):	V39								13
14	TOTAL			$	46,198	$ 913,636	$ 1,844	46,198	$ 915,480	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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 3/31/20 (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	$ 13,464,658	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 270,558)	2,192,988		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,418,607		5
6	Prepaid Insurance	231,642		6
7	Other Prepaid Expenses	370,008		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,677,903	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,851,797		12
13	Land	6,999,171		13
14	Buildings, at Historical Cost	155,523,100		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,245,409		16
17	Accumulated Depreciation (book methods)	(61,954,733)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,869,002		21
22	Other Long-Term Assets (spe See Attached	824,060		22
23	Other(specify): See Attached	81,825		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 140,439,631	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 158,117,534	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,407,225	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,737,315		29
30	Accrued Salaries Payable	1,965,285		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,324,398		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	103,198		33
34	Deferred Compensation	72,413		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	705,789		36
37	See Attached	3,928,356		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,243,979	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	65,568,160		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	57,617,415		43
44	See Attached	3,274,818		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 126,460,393	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 138,704,372	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 19,413,162	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 158,117,534	$	48

*(See instructions.)

Moorings of Arlington Hghts
0053967
3/31/20
Page 17 Support

PG 17 Line 9 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
Total			-

PG 17 Line 22 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1410.3	70-90-100-12810	Deposit LT	166,023.00
1430.7	70-20-100-10860	Entrance Fee Receivable	658,037.00
Total			824,060.00

PG 17 Line 23 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1200.99	70-90-010-15000	Fixed Assets Clearing	27,781.00
1200.99	70-90-100-15110	Construction in Progress	54,044.00
Total			81,825.00

PG 17 Line 36 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
2430.00	70-90-100-19610	Due To/From Geneva	89,873.00
2430.00	70-90-100-19710	Due To/From Corporate	(795,662.00)
Total			(705,789.00)

PG 17 Line 37 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2090.30	70-30-100-20515	Provider Tax Liability	(27,315.00)
2090.30	70-30-100-22020	Health Care Deposits	(441,499.00)
2090.30	70-20-100-23510	Deposits & Found Fee Adv	(385,542.00)
2090.30	70-20-100-23519	Refundable Entrance Fees	(3,074,000.00)
Total			(3,928,356.00)

PG 17 Line 43 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2450.10	70-20-100-23050	Long Term Refundable Entr Fees	(21,661,120.00)
2450.10	70-20-100-23055	Advance Refund To Resident A/R	260,820.00
2450.20	70-20-100-23010	Unamortized Entrance Fees	(36,217,115.00)
Total			(57,617,415.00)

PG 17 Line 44 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2450.30	70-90-100-20561	Accretion Liability-Asbestos	(66,429.00)
2450.30	70-20-100-21750	Swap Valuation	(3,208,389.00)
Total			(3,274,818.00)

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 27,889,374	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 27,889,374	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,253,997)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,253,997)	17
	B. Transfers (Itemize):		
18	**ILU & ALU net asset activity for the year**	(7,222,215)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (7,222,215)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 19,413,162	24 *

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

Facility Name & ID Number Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	$ 9,993,219	1
2	Discounts and Allowances for all Levels	(762,364)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,230,855	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,826,740	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,826,740	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	14,764	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	45,264	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,028	23
	D. Non-Operating Revenue		
24	Contributions	463,600	24
25	Interest and Other Investment Income***	7,131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 470,731	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)**	$ 11,588,354	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,521,093	31
32	Health Care	5,916,189	32
33	General Administration	4,140,269	33
	B. Capital Expense		
34	Ownership	1,085,342	34
	C. Ancillary Expense		
35	Special Cost Centers	329	35
36	Provider Participation Fee	179,129	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,842,351	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,253,997)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,253,997)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 144,582	44
45	Private Pay - Net Inpatient Revenue	6,524,129	45
46	Medicare - Net Inpatient Revenue	2,002,689	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	559,455	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,230,855	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

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	1,638	1,881	$ 130,010	$ 69.12	1
2	Assistant Director of Nursing	3,023	3,440	161,551	46.96	2
3	Registered Nurses	42,583	46,975	1,909,982	40.66	3
4	Licensed Practical Nurses	413	457	15,665	34.28	4
5	CNAs & Orderlies	79,566	87,950	1,634,536	18.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	810	981	30,154	30.74	9
10	Activity Assistants	8,575	10,047	174,936	17.41	10
11	Social Service Workers	3,575	4,301	136,315	31.69	11
12	Dietician					12
13	Food Service Supervisor	53	58	1,374	23.69	13
14	Head Cook	7,458	8,165	139,617	17.10	14
15	Cook Helpers/Assistants	18,366	20,003	270,782	13.54	15
16	Dishwashers	1,073	1,168	15,394	13.18	16
17	Maintenance Workers	2,771	3,115	70,234	22.55	17
18	Housekeepers	10,367	11,759	157,756	13.42	18
19	Laundry	4,232	4,704	59,671	12.69	19
20	Administrator	1,823	2,081	163,805	78.71	20
21	Assistant Administrator					21
22	Other Administrative	6,329	7,219	295,755	40.97	22
23	Office Manager					23
24	Clerical	2,781	3,096	72,671	23.47	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	1,388	1,597	33,882	21.22	31
32	Other Health Care: Security Svcs	2,768	3,157	73,948	23.42	32
33	Other(specify): Clinic	9	9	329	36.56	33
34	TOTAL (lines 1 - 33)	199,601	222,163	$ 5,548,367 *	$ 24.97	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	312	39,000	V09-03	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)	312	$ 39,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	909	27,510	V10-3	52
53	TOTAL (lines 50 - 52)	909	$ 27,510		53

Facility Name & ID Number: Moorings of Arlington Hghts # 0053967 Report Period Beginning: 4/1/19 Ending: 3/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Kaspar	Administrator	0.00%	$ 163,805
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 163,805

B. Administrative - Other

Description	Amount
Management Fees- Presbyterian Homes Manager	$ 850,605
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 850,605

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	See Attached	$ 151,326
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 151,326

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 349,575
Unemployment Compensation Insurance	15,990
FICA Taxes	404,468
Employee Health Insurance	882,156
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Educational Allowance and Other Benefits	4,944
Life Insurance	1,450
Long Term Disability Insurance	9,409
Retirement Benefits	224,623
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,892,615

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,924
Health Care Worker Background Check	1,199
(Indicate # of checks performed 41)	
Patient Background Checks	
License Fees	774
Membership & Publications	14,237
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,134

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	383
Seminar Expense	2,078
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,461

**See instructions.

Moorings of Arlington Hghts
0053967
3/31/20
Detail of Professional Fees

Date	Vendor	Description of Expense	Expense
3/31/2020	A V Powell & Associates LLC	Actuarial Valuation	5,210.00
3/31/2020	Plante & Moran, PLLC	Auditing, Tax Return and Cost Report Preparer	6,416.00
3/31/2020	Ability Network, Inc.	Data Processing	8,324.00
3/31/2020	Caremerge	Data Processing	2,776.00
3/31/2020	CDW Government Inc	Data Processing	13,947.00
3/31/2020	Dude Solutions	Data Processing	5,484.00
3/31/2020	Healthcaresourcehr, Inc.	Data Processing	3,456.00
3/31/2020	It'S Never 2 Late	Data Processing	3,145.00
3/31/2020	Knowbe4, Inc.	Data Processing	1,176.00
3/31/2020	Kronos	Data Processing	13,540.00
3/31/2020	Meridian It Inc	Data Processing	6,239.00
3/31/2020	Mimecast North America, Inc.	Data Processing	4,220.00
3/31/2020	Netsmart Technologies	Data Processing	14,395.00
3/31/2020	Nextgen Healthcare, Inc.	Data Processing	862.00
3/31/2020	Nexum, Inc.	Data Processing	11,966.00
3/31/2020	Onshift, Inc.	Data Processing	7,560.00
3/31/2020	Pc Connection Sales Corp	Data Processing	3,145.00
3/31/2020	Pinnacle Services, Inc	Data Processing	2,203.00
3/31/2020	Provinet Solutions	Data Processing	266.00
3/31/2020	Relias	Data Processing	8,574.00
3/31/2020	Status Solutions	Data Processing	2,423.00
3/31/2020	Teletech Corporation	Data Processing	179.00
3/31/2020	Touchtown	Data Processing	3,206.00
3/31/2020	Visual Touch Pos Solutions LLC	Data Processing	8,590.00
3/31/2020	Zoho	Data Processing	2,124.00
3/31/2020	Gould & Ratner	Legal (See Attached Schedule)	3,982.00
3/31/2020	Polsinelli	Legal (See Attached Schedule)	7,918.00
Total			151,326.00

Moorings of Arlington Hghts
0053967
3/31/20
Detail of Legal Expense

Date	General Ledger Accounts	Vendor	Description of Expense	Allow Expense
2/23/2020	70-30-100-69810	Polsinelli	Legal Service For Employee Matters	1,050.00
2/21/2020	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	442.00
11/18/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	582.00
9/23/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	1,443.00
12/17/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	419.00
10/17/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	392.00
7/19/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	70.00
7/19/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	284.00
5/20/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	93.00
4/23/2019	70-90-930-69810	Gould & Ratner	Legal Service For Employee Matters	70.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	263.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	228.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	210.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	210.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	210.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	158.00
10/10/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement	158.00
12/14/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement And Employee Matters	3,498.00
7/24/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement Review	1,841.00
7/24/2019	70-30-100-69810	Polsinelli	Legal Service For Residence And Service Agreement Review	94.00
12/17/2019	70-90-100-69810	Gould & Ratner	Legal Service For Residence And Service Agreement Review	185.00
Total				11,900.00

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. **N/A**

(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? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **96**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,990** Line **10-2**

(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. $ **179,129**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **24**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Plante Moran PLLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

PM STAFF - > COPY IN FROM TB FILE, IL MCD CR ENTRY TAB

PG 1 & 2

IDPH License ID Number:	0053967
Facility Name:	The Moorings Health Center
Street	
City	
Zip Code	
County	
Telephone Number:	
Fax #	
HFS ID Number:	
Date of Initial License for Current Owners:	
VOLUNTARY,NON-PROFIT	
Charitable Corp.	
Trust	
IRS Exemption Code	
PROPRIETARY	
Individual	
Partnership	
Corporation	
"Sub-S" Corp.	
Limited Liability Co.	
Trust	
Other	
Other	
GOVERNMENTAL	
State	
County	
Other	
Other	
Name:	
Telephone Number:	
Email Address:	
Beds at Beginning	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Beds at End	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Licensed Bed Days	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
MCD Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Private Pay Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
MCD Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Private Pay Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
All Other Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Medicare Days	5650.00

PG 3 & 4

A. General Services	Salary/Wage	Supplies	Other	Reclass	Adjustment
Dietary	427,167	30,771	94,720	-	-
Food Purchase	-	215,348	-	-	-
Housekeeping	157,756	31,425	16,861	-	-
Laundry	59,671	36,118	2,583	-	-
Heat and Other Utilities	-	-	158,128	-	-
Maintenance	125,482	150,351	14,712	-	-
Other (specify):*	-	-	-	-	-
TOTAL General Services					
B. Health Care and Programs					
Medical Director	0.00	0.00	39000.00	0.00	0.00
Nursing and Medical Records	3885626.00	#######	#######	0.00	0.00
Therapy	0.00	1844.00	#######	0.00	0.00
Activities	205090.00	3572.00	8440.00	0.00	0.00
Social Services	136315.00	126.00	176.00	0.00	0.00
CNA Training	0.00	0.00	0.00	0.00	0.00
Program Transportation	0.00	0.00	2251.00	0.00	0.00
Other (specify):*	0.00	0.00	0.00	0.00	0.00
TOTAL Health Care and Programs					
C. General Administration					
Administrative	163805.00	0.00	#######	0.00	#######
Directors Fees	0.00	0.00	0.00	0.00	0.00
Professional Services	0.00	0.00	#######	0.00	0.00
Dues, Fees, Subscriptions & Promotions	0.00	0.00	23134.00	0.00	0.00
Clerical & General Office Expenses	368426.00	18092.00	#######	0.00	#######
Employee Benefits & Payroll Taxes	0.00	0.00	#######	0.00	0.00
Inservice Training & Education	0.00	0.00	0.00	0.00	0.00
Travel and Seminar	0.00	0.00	2461.00	0.00	0.00
Other Admin. Staff Transportation	0.00	0.00	0.00	0.00	0.00
Insurance-Prop.Liab.Malpractice	0.00	0.00	#######	0.00	0.00
Other (specify):*	0.00	0	40091	0	-40091
D. Ownership					
Depreciation	0.00	0.00	#######	0.00	#######
Amortization of Pre-Op. & Org.	0.00	0	0	0	0
Interest	0.00	0	0	0	0
Real Estate Taxes	0.00	0	149092	0	0
Rent-Facility & Grounds	0.00	0	0	0	0
Rent-Equipment & Vehicles	0.00	0	22883	0	0
Other (specify):*	0.00	0	63094	0	-2776
TOTAL Ownership					
Ancillary Expense					
E. Special Cost Centers					
Medically Necessary Transportation	0.00	0	0	0	0
Ancillary Service Centers	0.00	0	0	0	0
Barber and Beauty Shops	0.00	0	0	0	0
Coffee and Gift Shops	0.00	0	0	0	0
Provider Participation Fee	0.00	0	179129	0	0
Other (specify):*	329.00	0	0	0	-329

PG 5 & 5A

Day Care	0.00
Other Care for Outpatients	0.00
Governmental Sponsored Special Program	0.00
Non-Patient Meals	0.00
Telephone, TV & Radio in Resident Room	0.00

PG 19

Item	Amount	
Gross Revenue -- All Levels of Care	9993219.00	
Discounts and Allowances for all Levels	-762364.00	
Day Care	0.00	
Other Care for Outpatients	0.00	
Therapy	1826740.00	
Oxygen	0.00	
Payments for Education	0.00	
Other Government Grants	0.00	
CNA Training Reimbursements	0.00	
Gift and Coffee Shop	0.00	
Barber and Beauty Care	0.00	
Non-Patient Meals	0.00	
Telephone, Television and Radio	0.00	
Rental of Facility Space	0.00	
Sale of Drugs	14764.00	
Sale of Supplies to Non-Patients	0.00	
Laboratory	0.00	
Radiology and X-Ray	0.00	
Other Medical Services	45264.00	
Laundry	0.00	
Contributions	463600.00	
Interest and Other Investment Income***	7131.00	
Settlement Income (Insurance, Legal, Etc	0.00	
OTHER1	0.00	AL/IL
OTHER2	0.00	Misc Revenue
General Services	1521093.00	
Health Care	5916189.00	
General Administration	4140269.00	
Ownership	1085342.00	
Special Cost Centers	329.00	
Provider Participation Fee	179129.00	
OTHER1	0.00	0
OTHER2	0.00	0
OTHER3	0.00	0
Income Taxes	0.00	
Medicaid - Net Inpatient Revenue	144582.00	
Private Pay - Net Inpatient Revenue	6524129.00	
Medicare - Net Inpatient Revenue	2002689.00	
Other-(specify)	559455.00	ALL OTHER SNF/SCF IP REVENUE
Other-(specify)	0.00	0

PG 20	Worked	Accrued	Wages
Director of Nursing	1638.00	1881	130010
Assistant Director of Nursing	3023.00	3440	161551
Registered Nurses	42583.00	46975	1909982
Licensed Practical Nurses	413.00	457	15665
CNAs & Orderlies	79566.00	87950	1634536
CNA Trainees	0.00	0.00	0.00
Licensed Therapist	0.00	0.00	0.00
Rehab/Therapy Aides	0.00	0.00	0.00
Activity Director	810.00	981	30154
Activity Assistants	8575.00	10047	174936
Social Service Workers	3575.00	4301	136315
Dietician	0.00	0.00	0.00
Food Service Supervisor	53.00	58	1374
Head Cook	7458.00	8165	139617
Cook Helpers/Assistants	18366.00	20003	270782
Dishwashers	1073.00	1168.00	15394.00
Maintenance Workers	2771.00	3115	70234
Housekeepers	10367.00	11759	157756
Laundry	4232.00	4704	59671
Administrator	1823.00	2081	163805
Assistant Administrator	0.00	0	0
Other Administrative	6329.00	7219.00	#######
Office Manager	0.00	0.00	0.00
Clerical	2781.00	3096	72671
Vocational Instruction	0.00	0.00	0.00
Academic Instruction	0.00	0.00	0.00
Medical Director	0.00	0.00	0.00
Qualified MR Prof. (QMRP)	0.00	0.00	0.00
Resident Services Coordinator	0.00	0.00	0.00
Habilitation Aides (DD Homes)	0.00	0.00	0.00
Medical Records	1388.00	1597	33882
Other Health Care(specify)	2768.00	3157.00	73948.00
Other(specify)	9.00	9	329
Dietary Consultant			
Medical Director			
Medical Records Consultant			
Nurse Consultant			
Pharmacist Consultant			
Physical Therapy Consultant			
Occupational Therapy Consultant			
Respiratory Therapy Consultant			
Speech Therapy Consultant			
Activity Consultant			
Social Service Consultant			
Other(specify)			
Other(specify)			
Other(specify)			

PAGE 17 CTB

Item	Amount
Cash on Hand and in Banks	
Cash-Patient Deposits	
Accounts & Short-Term Notes Receivable-	
Patients (less allowance	
Supply Inventory (priced at	
Short-Term Investments	
Prepaid Insurance	
Other Prepaid Expenses	
Accounts Receivable (owners or related parties)	
Other(specify):	
Long-Term Notes Receivable	
Long-Term Investments	
Land	
Buildings, at Historical Cost	
Leasehold Improvements, at Historical Cost	
Equipment, at Historical Cost	
Accumulated Depreciation (book methods)	
Deferred Charges	
Organization & Pre-Operating Costs	
Accumulated Amortization - Organization & Pre-Operating Costs	
Restricted Funds	
Other Long-Term Assets (specify):	
Other(specify):	
Accounts Payable	
Officer's Accounts Payable	
Accounts Payable-Patient Deposits	
Short-Term Notes Payable	
Accrued Salaries Payable	
Accrued Taxes Payable	
Accrued Real Estate Taxes(Sch.IX-B)	
Accrued Interest Payable	
Deferred Compensation	
Federal and State Income Taxes	
Other 1	
Other 2	
Long-Term Notes Payable	
Mortgage Payable	
Bonds Payable	
Deferred Compensation	
Other 1	
Other 2	
CTB Equity	

Record	Facility ID	Facility Name	Year	Location	City	County	Company	SNF Beds	SNF PED Beds	ICF Beds	ICF DD Beds	SC Beds	DD 16 Beds	Total Beds	Bed Days Available	Medicare Beds	Medicare Days	SNF - Medicaid Days	SNF - Private Days	SNF - Other Days	SNF - Total Days
	0053967	Moorings of Arlington Hghts	2020		Arlington Heigh	Cook		84	0	32	0	44	0	160	58,560	84	5,650	926	9,509	6,951	17,386

SNF PED - Medicaid Days	SNF PED - Private Days	SNF PED - Other Days	SNF PED - Total Days	ICF - Medicaid Days	ICF - Private Days	ICF - Other Days	ICF - Total Days	ICF DD - Medicaid Days	ICF DD - Private Days	ICF DD - Other Days	ICF DD - Total Days	SC - Medicaid Days	SC - Private Days	SC - Other Days	SC - Total Days	DD16 - Medicaid Days	DD16 - Private Days	DD16 - Other Days	DD16 - Total Days	Total Medicaid Days	Total Private Days	[illegible]
					7,239		7,239													926	16,748	[illegible]

10a - 2	10a - 3	10a - R	11 - 1	11 - 2	11 - 3	11 - R	12 - 1	12 - 2	12 - 3	12 - R	13 - 1	13 - 2	13 - 3	13 - R	14 - 1	14 - 2	14 - 3	14 - R	15 - 1	15 - 2	15 - 3	15 - R
1,844	913,636	915,480	205,090	3,572	8,440	217,102	136,315	126	176	136,617	0	0	0	0	0	0	2,251	2,251	0	0	0	0

17 - 1	17 - 2	17 - 3	17 - R	18 - 3	18 - R	19 - 3	19 - R	20 - 3	20 - R	21 - 1	21 - 2	21 - 3	21 - R	22 - 3	22 - R	23 - 3	23 - R	24 - 3	24 - R	25 - 2	25 - 3	25 - R
103,805	0	850,605	879,982	0	0	151,326	151,326	23,134	23,134	308,426	18,092	312,443	477,020	1,892,615	1,892,615	0	0	2,481	2,481	0	0	0

26 - 3	26 - R	27 - 1	27 - 2	27 - 3	27 - R	30 - 3	30 - R	31 - 3	31 - R	32 - 3	32 - R	33 - 3	33 - R	34 - 3	34 - R	35 - 3	35 - R	36 - 3	36 - R	38 - 1	38 - 2	38 - 3	38 - R	39 - 1	39 - 2	39 - 3
317,271	317,271	0	0	####	0	850,273	654,465	0	0	0	0	149,092	149,092	0	0	22,883	22,883	####	####	0	0	0	0	0	0	0

50 - 46 - 02	50 - 46 - 03	50 - 14 - 01	50 - 14 - 02	50 - 14 - 03	50 - 14 - 04	NULL 02	50 - 47 - 01	50 - 47 - 02	50 - 47 - 03	50 - 15 - 01	50 - 15 - 02	50 - 15 - 03	50 - 15 - 04	NULL 03	50 - 48 - 01	50 - 48 - 02	50 - 48 - 03	50 - 16 - 01	50 - 16 - 02	50 - 16 - 03	50 - 16 - 04
0		7,458	8,165	139,807	17.1		0	0		18,366	20,003	270,782	13.54		0	0		1,073	1,168	15,594	13.18

50 - 17 - 01	50 - 17 - 02	50 - 17 - 03	50 - 17 - 04	50 - 49 - 01	50 - 49 - 02	50 - 18 - 01	50 - 18 - 02	50 - 18 - 03	50 - 18 - 04	50 - 19 - 01	50 - 19 - 02	50 - 19 - 03	50 - 19 - 04	50 - 20 - 01	50 - 20 - 02	50 - 20 - 03	50 - 20 - 04	50 - 21 - 01	50 - 21 - 02	50 - 21 - 03	50 - 21 - 04	[illegible]
2,771	3,115	70,234	22.55	512	39,000	10,387	11,759	157,756	13.42	4,232	4,704	59,671	12.69	1,893	2,681	103,805	78.71	0	0	0		[illegible]

50 - 29 - 02	50 - 29 - 03	50 - 29 - 04	50 - 52 - 01	50 - 52 - 02	50 - 52 - 03	50 - 30 - 01	50 - 30 - 02	50 - 30 - 03	50 - 30 - 04	50 - 31 - 01	50 - 31 - 02	50 - 31 - 03	50 - 31 - 04	50 - 53 - 01	50 - 53 - 02	NULL 04	50 - 32 - 01	50 - 32 - 02	50 - 32 - 03	50 - 32 - 04
0	0		909	27,520	V10-3	0	0	0		1,388	1,527	33,882	21.22	909	27,520		2,768	3,157	73,948	23.42

NULL 05	50 - 33 - 01	50 - 33 - 02	50 - 33 - 03	50 - 33 - 04	50 - 34 - 01	50 - 34 - 02	50 - 34 - 03	50 - 34 - 04
	0	0	399	36.58	199,601	222,103	5,548,397	24.97

39-8	40-1	40-2	40-3	40-8	41-1	41-2	41-3	41-8	42-1	42-2	42-3	42-8	43-1	43-2	43-3	43-8	50-01-01	50-01-02	50-01-03
0	0	0	0	0	0	0	0	0	0	0	179,129	179,129	329	0	0	0	1,858	1,881	130,000

50-01-04	50-02-01	50-02-02	50-02-03	50-02-04	50-35-01	50-35-02	50-35-03	50-03-01	50-03-02	50-03-03	50-03-04	50-36-01	50-36-02	50-36-03	50-04-01	50-04-02	50-04-03	50-04-04	50-37-01
69	3,023	3,440	116,551	46.96	0	0	0	42,583	46,275	1,909,282	40.66	312	39,000	109.03	413	457	15,605	34.28	0

50-37-02	50-37-03	50-05-01	50-05-02	50-05-03	50-05-04	50-38-01	50-38-02	50-38-03	50-06-01	50-06-02	50-06-03	50-06-04	50-39-01	50-39-02	50-39-03	50-07-01	50-07-02	50-07-03	50-07-04
0	0	79,586	87,950	1,834,536	18.58	0	0	0	0	0	0		0	0	0	0	0	0	

50-40-01	50-40-02	50-40-03	50-08-01	50-08-02	50-08-03	50-08-04	50-41-01	50-41-02	50-41-03	50-09-01	50-09-02	50-09-03	50-09-04	50-42-01	50-42-02	50-42-03	50-10-01	50-10-02	50-10-03
0	0		0	0	0		0	0		810	981	30,154	30.74	0	0		8,575	10,047	174,936

50-10-04	50-43-01	50-43-02	50-43-03	50-11-01	50-11-02	50-11-03	50-11-04	50-44-01	50-44-02	50-44-03	50-12-01	50-12-02	50-12-03	50-12-04	50-45-01	50-45-02	50-45-03	50-13-01	50-13-02	50-13-03	50-13-04	NULL-01	50-46-01
17.41	0	0		3,575	4,300	136,315	31.69	0	0		0	0	0		0	0		53	58	1,374	23.69		0