

Facility Name & ID Number MOORE HOUSE

0030593 Report Period Beginning: 07/01/09 Ending: 06/30/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,390			5,390	13
14	TOTALS	5,390			5,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.45%

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

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/30/86

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

YES Date 07/01/86 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 06/30/10

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

Facility Name & ID Number **MOORE HOUSE** # **0030593** Report Period Beginning: **07/01/09** Ending: **06/30/10**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	26,700	1,519	3,651	31,870		31,870		31,870		1
2	Food Purchase		24,422		24,422		24,422		24,422		2
3	Housekeeping	18,516	1,360		19,876		19,876		19,876		3
4	Laundry		4,366		4,366		4,366		4,366		4
5	Heat and Other Utilities			14,918	14,918		14,918		14,918		5
6	Maintenance	14,604	3,131	17,187	34,922		34,922		34,922		6
7	Other (specify):*			3,012	3,012		3,012		3,012		7
8	TOTAL General Services	59,820	34,798	38,768	133,386		133,386		133,386		8
	B. Health Care and Programs										
9	Medical Director			2,200	2,200		2,200		2,200		9
10	Nursing and Medical Records	164,447	7,185	6,830	178,462		178,462	(3,280)	175,182		10
10a	Therapy			7,446	7,446		7,446		7,446		10a
11	Activities		52	3,067	3,119		3,119		3,119		11
12	Social Services	13,926			13,926		13,926		13,926		12
13	CNA Training		713	490	1,203		1,203		1,203		13
14	Program Transportation			1,485	1,485		1,485		1,485		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	178,373	7,950	21,518	207,841		207,841	(3,280)	204,561		16
	C. General Administration										
17	Administrative	93,939		62,377	156,316		156,316		156,316		17
18	Directors Fees										18
19	Professional Services			3,982	3,982		3,982		3,982		19
20	Dues, Fees, Subscriptions & Promotions			3,295	3,295		3,295		3,295		20
21	Clerical & General Office Expenses	10,209	6,873	16,817	33,899		33,899		33,899		21
22	Employee Benefits & Payroll Taxes			83,326	83,326		83,326		83,326		22
23	Inservice Training & Education			802	802		802		802		23
24	Travel and Seminar			2,399	2,399		2,399	(804)	1,595		24
25	Other Admin. Staff Transportation			6,791	6,791		6,791		6,791		25
26	Insurance-Prop.Liab.Malpractice			4,236	4,236		4,236		4,236		26
27	Other (specify):*			4,267	4,267		4,267	(2,164)	2,103		27
28	TOTAL General Administration	104,148	6,873	188,292	299,313		299,313	(2,968)	296,345		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	342,341	49,621	248,578	640,540		640,540	(6,248)	634,292		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,270	23,270		23,270	(2,245)	21,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,744	23,744		23,744		23,744			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			7,302	7,302		7,302		7,302			34
35	Rent-Equipment & Vehicles			9,187	9,187		9,187		9,187			35
36	Other (specify):*											36
37	TOTAL Ownership			63,503	63,503		63,503	(2,245)	61,258			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			38,048	38,048		38,048		38,048			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,048	38,048		38,048		38,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	342,341	49,621	350,129	742,091		742,091	(8,493)	733,598			45

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

MOORE HOUSE

ID# 0030593

Report Period Beginning: 07/01/09

Ending: 06/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12	Medical & Dental Service Payments	(3,280)	10	12
13	Out-of-Town Travel	(804)	24	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	(4,084)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOORE HOUSE# 0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(3,280)	0	0	0	0	0	0	0	0	0	0	(3,280)	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	(3,280)	0	(3,280)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(804)	0	0	0	0	0	0	0	0	0	0	(804)	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):*	(2,164)	0	0	0	0	0	0	0	0	0	0	(2,164)	27
28	TOTAL General Administration	(2,968)	0	(2,968)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,248)	0	(6,248)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOORE HOUSE# 0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,493)	0	0	0	0	0	0	0	0	0	0	(8,493)	45

Facility Name & ID Number

MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Hammond House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Voluntary Health
		Davis House	Chicago, IL	Ada S. Mckinley	Chicago, IL	and Welfare
		Knight House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Agency
		Danforth House	Chicago, IL	Ada S. Mckinley	Chicago, IL	

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Ada S. McKinley Community Services, Inc.

Street Address

725 S. Wells St.

City / State / Zip Code

Chicago, IL

Phone Number

(312) 385-2000

Fax Number

(312) 554-8161

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	Ln. 17	Central Administration Exp.	Direct Cost	35,566,628	97	\$ 3,308,980	\$ 1,748,477	656,445	\$ 61,073	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,566,628	97	70,630		656,445	1,304	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					\$ 3,379,610	\$ 1,748,477		\$ 62,377	25

Facility Name & ID Number

MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

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										
										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	H.U.D.	X	Mortgage	\$2,657.00	12/01/86	\$ 334,060	\$ 252,223	12/1/2027	0.0925	\$ 23,744	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$2,657.00		\$ 334,060	\$ 252,223			\$ 23,744	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 334,060	\$ 252,223			\$ 23,744	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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.

1. Real Estate Tax accrual used on 2009 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOORE HOUSE COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030593

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,680 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One (1)

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>ICF/DD</u>		<u>1982</u>	<u>\$ 14,846</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 14,846	3

Facility Name & ID Number MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	15	1986	1986	\$ 328,040	\$ 13,122	25	\$ 10,935	\$ (2,187)	\$ 308,358	4
5			1988	8,618	345	25	287	(58)	7,929	5
6			1999	13,000		10			13,000	6
7			2000	2,125	177	12	177		1,859	7
8			2002	10,460	1,046	10	1,046		8,542	8
Improvement Type**										
9	Janitrol 70,000 BTU furnace		2002	3,200		5			3,200	9
10	Brick tuckpointing, washroom, laundry room, & kitchen repair		2004	14,975	1,497	5	1,497		9,547	10
11	5-ton Janitrol condensing unit		2008	1,600	320	5	320		920	11
12	Bathroom renovations		2008	21,151	2,115	10	2,115		5,905	12
13	Bathroom renovations - additional		2008	1,994	199	10	199		440	13
14	Luxaire upflow furnace		2008	1,800	360	5	360		975	14
15	Luxaire upflow furnace		2008	1,800	360	5	360		975	15
16	AO Smith 100 gal. hot water tank		2008	4,200	840	5	840		2,135	16
17	Commercial dishwasher		2010	4,921	123	5	123		123	17
18	Commercial dishwasher		2010	4,922	123	5	123		123	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

*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 MOORE HOUSE

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 422,806	\$ 20,627		\$ 18,382	\$ (2,245)	\$ 364,031	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 13,433	\$ 2,607	\$ 2,607	\$	5 Years	\$ 7,442	71
72	Current Year Purchases	197	36	36		5 Years	36	72
73	Fully Depreciated Assets	63,108				5 Years	63,108	73
74								74
75	TOTALS	\$ 76,738	\$ 2,643	\$ 2,643	\$		\$ 70,586	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	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)	\$ 514,390	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,270	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,025	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,245)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 434,617	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Samaritas, Inc. - Division Office Allocated Rent

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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:				\$ <u>7,302</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>7,302</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,925 Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Staff transportation</u>	<u>2006 Toyota Sienna</u>	\$ <u>438.45</u>	\$ <u>5,262</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>438.45</u>	\$ <u>5,262</u>	21

10. Effective dates of current rental agreement:

Beginning 07/01/09

Ending 06/30/10

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

Fiscal Year Ending Annual Rent

12. /2011 \$ _____

13. /2012 \$ _____

14. /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
---	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		713		713
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		490		490
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,203	\$	\$ 1,203
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,203		

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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 **MOORE HOUSE**

0030593

Report Period Beginning: **07/01/09**

Ending: **06/30/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/10**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 594,432	1
2	Cash-Patient Deposits		159,898	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>319,848</u>)		9,337,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		166,446	6
7	Other Prepaid Expenses		108,837	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 10,367,244	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		399,606	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,702,680	14
15	Leasehold Improvements, at Historical Cost		2,082,363	15
16	Equipment, at Historical Cost		4,573,645	16
17	Accumulated Depreciation (book methods)		(10,994,797)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		273,138	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Issue Costs, Security Deposits</u>		73,876	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 5,066,010	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 15,433,254	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 2,529,694	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		165,144	28
29	Short-Term Notes Payable		722,561	29
30	Accrued Salaries Payable		2,639,034	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		25,035	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		164,857	35
Other Current Liabilities(specify):				
36	<u>Unfunded Pension Liability</u>		172,723	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 6,419,048	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,736,776	40
41	Bonds Payable		1,050,000	41
42	Deferred Compensation		45,615	42
Other Long-Term Liabilities(specify):				
43	<u>Pension Benefit Liability</u>		6,037,451	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,869,842	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 15,288,890	46
47	TOTAL EQUITY(page 18, line 24)	\$ 144,364	\$ 144,364	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 144,364	\$ 15,433,254	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (81,851)	1
2	Restatements (describe):		2
3	Beginning Balance - Other Operating Units	2,653,806	3
4	Prior Year's Adjustment	(2,807,420)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (235,465)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	80,890	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) Operating Income-Other Operating Units	298,939	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 379,829	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 144,364	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MOORE HOUSE

0030593

Report Period Beginning: 07/01/09

Ending: 06/30/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 698,740	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 698,740	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	109,053	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 109,053	23
D. Non-Operating Revenue			
24	Contributions	14,000	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,000	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Proceeds, miscellaneous	1,188	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,188	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 822,981	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	133,386	31
32	Health Care	207,841	32
33	General Administration	299,313	33
B. Capital Expense			
34	Ownership	63,503	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,048	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 742,091	40
41	Income before Income Taxes (line 30 minus line 40)**	80,890	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 80,890	43

* 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 **MOORE HOUSE**

0030593

Report Period Beginning:

07/01/09

Ending:

06/30/10

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
2	Assistant Director of Nursing				2
3	Registered Nurses	534	14,825	24.63	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers	391	13,926	31.22	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,824	26,700	12.84	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	752	14,604	17.10	17
18	Housekeepers	1,824	18,516	8.90	18
19	Laundry				19
20	Administrator	286	13,665	41.79	20
21	Assistant Administrator	1,824	58,541	28.14	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	746	10,209	12.42	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,088	21,733	17.67	29
30	Habilitation Aides (DD Homes)	13,403	149,622	10.03	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	22,672	342,341 *	\$ 13.45	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	80	\$ 3,651	Ln.1,Col.3	35
36	Medical Director	22	2,200	Ln.9,Col.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	750	Ln.10,Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	2,394	Ln.10a,Col.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	75	4,860	Ln.10a,Col.3	46
47	<u>Psychiatrist</u>	2	192	Ln.10a,Col.3	47
48	<u>Dental</u>	87	3,280	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	327	\$ 17,327		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	47	\$ 2,800	Ln.10,Col.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	47	\$ 2,800		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Albert Cueller III	Div. Director		\$ 13,665	Workers' Compensation Insurance	\$ 3,270	IDPH License Fee	\$		
Jocelyn Nichols	Center Director		58,541	Unemployment Compensation Insurance	1,194	Advertising: Employee Recruitment		482	
Nerlene Dossous	Staff Trng. Coord.		1,559	FICA Taxes	25,423	Health Care Worker Background Check			
S. Tyler/V. Taylor	Service Coord.		11,407	Employee Health Insurance	14,057	(Indicate # of checks performed _____)			
H. Fly/B. Johnson-Baxter	Health Svcs. Coord.		1,654	Employee Meals		Patient Background Checks			
Robbye Fulghum	Outreach Coord.		7,113	Illinois Municipal Retirement Fund (IMRF)*		Staff Literature & Library		298	
				Retirement Income Plan	36,090	Membership Dues		1,916	
				Retirement Plan Fees	1,020	Permits & Licenses		574	
				Life Insurance	2,272	Professional Fees		25	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,939						
B. Administrative - Other									
Description			Amount						
Central Office - Management & General			\$ 62,377						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 62,377						
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**		
Washington, Pittman & McKeever	Auditors		\$ 1,827	N/A		\$	Description	Amount	
Verify	Computers		332				Out-of-State Travel	\$	
Others			1,823						
							In-State Travel	1,595	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,982	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,595	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MOORE HOUSE

0030593

Report Period Beginning: 07/01/09

Ending: 06/30/10

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? No If YES, what is the capacity? N/A
- (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? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 612 Line 27
- (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. \$ 38,048
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? N/A
- (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? N/A Indicate the amount. \$ N/A
- (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? 18%
- d. Have vehicle usage logs been maintained? Yes
- 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? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ None
- (17) Has an audit been performed by an independent certified public accounting firm? On-going
Firm Name: Washington, Pittman & McKeever, LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - COLUMN 3, LINE 7 - OTHERS - GENERAL SERVICES
FISCAL YEAR 2010 COST REPORT

MOORE HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/02/09	281,786	PMTRX00006010	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354.00
09/24/09	289,580	PMTRX00006156	ACCT. #2808	LUX SECURITY SYSTEMS, CO.	700.00
09/30/09	289,942	PMTRX00006169	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354.00
12/11/09	296,778	PMTRX00006281	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354.00
03/30/10	306,246	PMTRX00006463	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354.00
06/30/10	327,067	GLTRX00031690	Reclass RSD expenses	ADT SECURITY SERVICES INC.	895.88
					\$ 3,011.88

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION
 FISCAL YEAR 2010 COST REPORT

MOORE HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Ref.	Vendor	Amount
09/30/09	290,938	PMTRX00006187	PTY. CSH. F/09/09	JOCELYN NICHOLS - PETTY CASH	16.02
11/29/09	69,661	GLTRX00029648	Variable Allocation - 11/09	Variable Allocation	121.44
11/30/09	296,952	PMTRX00006284	PTY. CSH. F/12/09	JOCELYN NICHOLS - PETTY CASH	18.37
12/29/09	69,661	GLTRX00029926	Variable Allocation - 12/09	Variable Allocation	394.37
01/29/10	69,661	GLTRX00030129	Variable Allocation - 01/10	Variable Allocation	1.24
01/31/10	301,633	PMTRX00006367	PTY. CSH. F/01/10	JOCELYN NICHOLS - PETTY CASH	26.46
02/28/10	69,661	GLTRX00030379	Variable Allocation - 02/10	Variable Allocation	22.56
05/31/10	311,924	PMTRX00006593	PTY. CSH. F/05/10	JOCELYN NICHOLS - PETTY CASH	9.10
06/30/10	327,067	GLTRX00031690	Reclass RSD expenses	RSD expenses	155.11
07/31/09	286,035	PMTRX00006091	E.E.A F/07/09	ALBERT CUELLER III	0.61
11/29/09	69,661	GLTRX00029648	Variable Allocation - 11/09	Variable Allocation	8.70
12/29/09	69,661	GLTRX00029926	Variable Allocation - 12/09	Variable Allocation	26.16
01/29/10	69,661	GLTRX00030129	Variable Allocation - 01/10	Variable Allocation	0.09
02/28/10	69,661	GLTRX00030379	Variable Allocation - 02/10	Variable Allocation	1.60
					\$ 801.83

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE XIX-G (Page 21) - ANALYSIS OF IN-STATE TRAVEL AND SEMINAR - Account 3310
FOR THE FISCAL YEAR ENDED JUNE 30, 2010

MOORE HOUSE

DATE	JE No.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	ACCOUNT 3310				Account	In-State
										15177080	15178880	15000031	Total	3330	Travel & Seminar
										Amount	Amount	Amount		Amount	
09/30/09	289,928	120500	AAHSA REGISTRAR	AAHSA Service Coordinator Conference	Chicago, IL	G. Ellis/P. Halliburton	Service Coordinators	November 7-11, 2009	AAHSA				368.00		368.00
10/13/09	290,992	120728	INHAA	Illinois Nursing Home Administrators' Association Conference	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	November 3-4, 2009	INHAA	45.00			45.00		45.00
10/19/09	291,756	120932	IARF	IARF 34th Annual Conference and Expo	Peoria, IL	Jocelyn Peterson	Center Director	October 27-29, 2009	IARF	319.00			319.00		319.00
10/19/09	291,756	120932	IARF	IARF 34th Annual Conference and Expo	Peoria, IL	Albert Cueller III	Division Director	October 27-29, 2009	IARF		1.14	2.00	3.14		3.14
01/20/10	300,098	122604	ARC OF ILLINOIS	8th Annual QMRP Leadership Conference	Alsip, IL	Jocelyn Peterson	Center Director	January 26, 2010	ARC OF ILLINOIS	108.00			108.00		108.00
11/30/09	295,915	121885	I.C.A.N., INC.	ICAN Conference	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	October 31, 2009	ICAN			20.00	20.00		20.00
01/31/10	302,646		AMEX 08/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	July 29-30, 2009	Ada S. McKinley Community Services, Inc.		21.40	37.55	58.95		58.95
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		1.47	2.58	4.05		4.05
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		7.02	12.32	19.34		19.34
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		0.19	0.33	0.52		0.52
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		0.83	1.46	2.29		2.29
01/31/10	304,888		AMEX 11/09	IARF 34th Annual Conference and Expo	Peoria, IL	Albert Cueller III & \$ staff	Division Director & 4 staff	October 27-29, 2009	IARF			64.11	64.11		64.11
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	Robbye Fulghum	Outreach Coordinator/COS	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS			36.00	36.00		36.00
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	V. Taylor & S. Tyler	Service Coordinators	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS		72.00		72.00		72.00
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	Albert Cueller III	Division Director	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS		10.26	18.00	28.26		28.26
06/30/10	326,391		AMEX 04/10	Business meal	Springfield, IL	Albert Cueller III	Division Director	April 28, 2010	Ada S. McKinley Community Services, Inc.			3.47	5.45		5.45
06/30/10	326,409		AMEX 06/10	Violence Prevention	Chicago, IL	Paulette Stallworth	Director - Habilitation Services	June 10, 2010	IANCICI	64.30			64.30		64.30
Various	Various	Various	Various	Business meals	Various	Various	Various						-	376.84	376.84
TOTAL MOORE HOUSE										\$ 536.30	\$ 484.29	\$ 197.82	\$ 1,218.41	\$ 376.84	\$ 1,595.25

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2010 COST REPORT

DESCRIPTION	MOORE HOUSE
Mileage and auto rental	\$ 4,398
Gasoline and vehicle repairs	1,532
Automobile insurance	861
	\$ 6,791

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2010 COST REPORT

DESCRIPTION	MOORE HOUSE
Other Staff Expenses	\$ 209
Client Benefits - Accident Insurance	67
Clothing & Personal Needs	2,164
Miscellaneous	92
Misc Exps-Service Coordinator	1,735
	\$ 4,267