

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0030577</u></p> <p><b>Facility Name:</b> <u>Danforth House</u></p> <p><b>Address:</b> <u>4540 South Michigan Avenue</u> <u>Chicago</u> <u>60653</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 373-1073</u> Fax # <u>(773) 373-1867</u></p> <p><b>HFS ID Number:</b> <u>36-2144820-004</u></p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:  <b>Name:</b> <u>Adrienne Golembiewski</u> <b>Telephone Number:</b> <u>(312) 385-2000</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/05</u> to <u>06/30/06</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) <u>HANS J. SCHUSTER</u></td> </tr> <tr> <td></td> <td colspan="2">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) _____</td> </tr> <tr> <td colspan="2">(Telephone) ( ) _____ Fax # ( ) _____</td> </tr> <tr> <td colspan="2">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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>HANS J. SCHUSTER</u>			(Title) <u>Chief Financial Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) ( ) _____ Fax # ( ) _____		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																										
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Facility Name & ID Number Danforth House

# 0030577 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,124			5,124	13
14	TOTALS	5,124			5,124	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.59%

D. How many bed-hold days during this year were paid by the Department? 318 (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 11/07/86

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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number Danforth House

# 0030577

Report Period Beginning: 07/01/05

Ending: 06/30/06

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	25,442	2,249	3,201	30,892		30,892		30,892		1
2	Food Purchase		38,666		38,666		38,666		38,666		2
3	Housekeeping	15,814	364		16,178		16,178		16,178		3
4	Laundry		1,064		1,064		1,064		1,064		4
5	Heat and Other Utilities			13,334	13,334		13,334		13,334		5
6	Maintenance	18,816	12,804	12,774	44,394		44,394		44,394		6
7	Other (specify):*			3,457	3,457		3,457		3,457		7
8	<b>TOTAL General Services</b>	<b>60,072</b>	<b>55,147</b>	<b>32,766</b>	<b>147,985</b>		<b>147,985</b>		<b>147,985</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,600	2,600		2,600		2,600		9
10	Nursing and Medical Records	149,572	5,292	2,210	157,074		157,074	(1,310)	155,764		10
10a	Therapy			17,580	17,580		17,580		17,580		10a
11	Activities			4,269	4,269		4,269		4,269		11
12	Social Services	15,304			15,304		15,304		15,304		12
13	CNA Training		280	93	373		373		373		13
14	Program Transportation			1,644	1,644		1,644		1,644		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>164,876</b>	<b>5,572</b>	<b>28,396</b>	<b>198,844</b>		<b>198,844</b>	<b>(1,310)</b>	<b>197,534</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	91,168		58,086	149,254		149,254		149,254		17
18	Directors Fees										18
19	Professional Services			8,447	8,447		8,447		8,447		19
20	Dues, Fees, Subscriptions & Promotions			3,569	3,569		3,569		3,569		20
21	Clerical & General Office Expenses	12,955	5,226	5,953	24,134		24,134		24,134		21
22	Employee Benefits & Payroll Taxes			89,965	89,965		89,965		89,965		22
23	Inservice Training & Education			846	846		846		846		23
24	Travel and Seminar			3,124	3,124		3,124	(1,956)	1,168		24
25	Other Admin. Staff Transportation			4,577	4,577		4,577		4,577		25
26	Insurance-Prop.Liab.Malpractice			4,975	4,975		4,975		4,975		26
27	Other (specify):*			1,501	1,501		1,501	(1,187)	314		27
28	<b>TOTAL General Administration</b>	<b>104,123</b>	<b>5,226</b>	<b>181,043</b>	<b>290,392</b>		<b>290,392</b>	<b>(3,143)</b>	<b>287,249</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>329,071</b>	<b>65,945</b>	<b>242,205</b>	<b>637,221</b>		<b>637,221</b>	<b>(4,453)</b>	<b>632,768</b>		<b>29</b>

\*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 Danforth House

#0030577

Report Period Beginning:

07/01/05

Ending:

06/30/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											30
	Depreciation			18,741	18,741		18,741	(2,244)	16,497			
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,253	26,253		26,253		26,253			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			10,986	10,986		10,986		10,986			34
35	Rent-Equipment & Vehicles			7,822	7,822		7,822		7,822			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			63,802	63,802		63,802	(2,244)	61,558			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			40,916	40,916		40,916		40,916			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			40,916	40,916		40,916		40,916			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	329,071	65,945	346,923	741,939		741,939	(6,697)	735,242			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 Danforth House

# 0030577

Report Period Beginning:

07/01/05

Ending:

06/30/06

VI. ADJUSTMENT DETAIL

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

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

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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 Room:				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(2,244)	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				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(1,187)	27		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer:				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 CNA Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,431)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (3,431)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Danforth House

ID# 0030577

Report Period Beginning: 07/01/05

Ending: 06/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	(1,310)	10	12
13	Out-of-Town Travel	(1,956)	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	<b>Total</b>	(3,266)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Danforth House

# 0030577

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>1</b>	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,310)	0	0	0	0	0	0	0	0	0	0	(1,310)	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	<b>TOTAL Health Care and Programs</b>	<b>(1,310)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,310)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(1,956)	0	0	0	0	0	0	0	0	0	0	(1,956)	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):*	(1,187)	0	0	0	0	0	0	0	0	0	0	(1,187)	27
28	<b>TOTAL General Administration</b>	<b>(3,143)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,143)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,453)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,453)</b>	<b>29</b>



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
		Moore House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Voluntary Health
		Hammond House	Chicago, IL	Ada S. Mckinley	Chicago, IL	and Welfare
		Davis House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Agency
		Knight 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:
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)
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number Danforth House # 0030577 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 Danforth House # 0030577 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 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

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	<u>Ln. 17</u>	<u>Central Administration Exp.</u>	<u>Direct Cost</u>	<u>35,045,209</u>	<u>101</u>	<u>\$ 3,063,193</u>	<u>\$ 1,637,173</u>	<u>\$ 56,610</u>	1
2	<u>Ln. 17</u>	<u>Central Administration Exp.</u>	<u>Direct Cost</u>	<u>35,045,209</u>	<u>101</u>	<u>79,921</u>	<u>647,657</u>	<u>1,476</u>	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	<b>TOTALS</b>					<b>\$ 3,143,114</b>	<b>\$ 1,637,173</b>	<b>\$ 58,086</b>	<b>25</b>

Facility Name & ID Number Danforth House # 0030577 Report Period Beginning: 07/01/05 Ending: 06/30/06

**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	Name of Lender	2		3	4	5	6		7	8	9	10
			Related**					Purpose of Loan	Monthly Payment Required				
			YES	NO				Original	Balance				
		<b>A. Directly Facility Related</b>											
		<b>Long-Term</b>											
1		H.U.D.		X	Mortgage	\$2,657.00	12/01/86	\$ 334,060	\$ 280,721	12/1/2027	0.0925	\$ 26,253	1
2													2
3													3
4													4
5													5
		<b>Working Capital</b>											
6													6
7													7
8													8
9		<b>TOTAL Facility Related</b>				\$2,657.00		\$ 334,060	\$ 280,721			\$ 26,253	9
		<b>B. Non-Facility Related*</b>											
10													10
11													11
12													12
13													13
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15		<b>TOTALS (line 9+line14)</b>						\$ 334,060	\$ 280,721			\$ 26,253	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2005 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 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="3"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	8																															
2002	9																															
2003	10																															
2004	11																															
2005	12																															
<b>FOR BHF USE ONLY</b>																																
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																													
14	PLUS APPEAL COST FROM LINE 5	\$	14																													
15	LESS REFUND FROM LINE 6	\$	15																													
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																													

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Danforth House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030577

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 direct used for nursing home services?        YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

**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 Danforth House

# 0030577 Report Period Beginning:

07/01/05 Ending:

06/30/06

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 ground: (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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	ICF/DD		1984	\$ 19,976	1
2					2
3	TOTALS			\$ 19,976	3

Facility Name & ID Number Danforth House

# 0030577

Report Period Beginning:

07/01/05

Ending:

06/30/06

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)	\$ 255,872
5			1988	8,618	344	25	287	(57)	6,548
6			1999	13,000	1,300	10	1,300		9,750
7									
8									
<b>Improvement Type**</b>									
9	Roof and gutter replacements		2002	10,460	1,046	10	1,046		4,359
10	135,000 BTU furnace		2004	2,495	499	5	499		1,310
11	New lights in common hallways, repair of walls, concreting,								
12	& washroom, dining room, bedrooms, & bathroom repairs		2004	11,433	1,144	10	1,144		2,620
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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)		\$ 374,046	\$ 17,455		\$ 15,211	\$ (2,244)	\$ 280,459	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	\$ 6,597	\$ 1,037	\$ 1,037		5 Years	\$ 3,603	71
72	Current Year Purchases	1,244	249	249		5 Years	249	72
73	Fully Depreciated Assets	24,147					24,147	73
74								74
75	<b>TOTALS</b>	\$ 31,988	\$ 1,286	\$ 1,286			\$ 27,999	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	<b>TOTALS</b>			\$	\$	\$			\$	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)	\$ 426,010	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,741	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,497	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,244)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 308,458	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	<b>TOTALS</b>	\$	\$	\$	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.

Facility Name & ID Number Danforth House# 0030577Report Period Beginning: 07/01/05Ending: 06/30/06**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?

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:				\$ 10,986			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ 10,986			7

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

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

 YES  NO16. Rental Amount for movable equipment: \$ 3,524 Description: Copiers, computers, printers, fax machines

(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>2003 Dodge Caravan</u>	\$ <u>358.16</u>	\$ <u>4,298</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>358.16</u>	\$ <u>4,298</u>	21

10. Effective dates of current rental agreement:  
Beginning 07/01/05  
Ending 06/30/06

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

Fiscal Year Ending Annual Rent

12. /2007 \$ \_\_\_\_\_  
13. /2008 \$ \_\_\_\_\_  
14. /2009 \$ \_\_\_\_\_\* 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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b> <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><b>2. CLASSROOM PORTION:</b></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>40</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		280		280
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments		93		93
8 CNA Competency Tests				
9 TOTALS	\$	\$ 373	\$	\$ 373
10 SUM OF line 9, col. 1 and 2 (e)	\$	373		

- (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.

**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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			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	Exceptional Care Program											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 &amp; ID Number Danforth House

# 0030577

Report Period Beginning: 07/01/05

Ending:

06/30/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 2,152,487	1
2	Cash-Patient Deposits		121,115	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 129,101 )		4,405,525	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		91,026	6
7	Other Prepaid Expenses		182,447	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 6,952,600	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable		649,234	11
12	Long-Term Investments			12
13	Land		888,499	13
14	Buildings, at Historical Cost		6,600,931	14
15	Leasehold Improvements, at Historical Cost		1,945,672	15
16	Equipment, at Historical Cost		4,229,430	16
17	Accumulated Depreciation (book methods)		(9,023,977)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		343,171	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Issue Costs, Security Deposits</u>		115,616	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 5,748,576	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 12,701,176	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 1,955,361	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		121,064	28
29	Short-Term Notes Payable		6,595	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)		2,438,541	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,284	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		144,547	35
<b>Other Current Liabilities(specify):</b>				
36	<u>Unfunded Pension Liability</u>		128,990	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 4,808,382	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		26,760	39
40	Mortgage Payable		1,403,605	40
41	Bonds Payable		1,620,000	41
42	Deferred Compensation		23,651	42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,074,016	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 7,882,398	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,818,778	\$ 4,818,778	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,818,778	\$ 12,701,176	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 316,859	1
2	Restatements (describe):		2
3	Beginning Balance, Other Operating Units	4,217,494	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,534,353	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	60,749	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) <b>Operating Income-Other Operating Units</b>	223,676	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 284,425</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 4,818,778</b>	24 *

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

## STATE OF ILLINOIS

Page 19

Facility Name & ID Number Danforth House# 0030577Report Period Beginning: 07/01/05Ending: 06/30/06

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 695,491	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 695,491	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	106,926	10
11	CNA Training Reimbursements	69	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 106,995	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Insurance Proceeds, Jury Duty</u>	202	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 202	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 802,688	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	147,985	31
32	Health Care	198,844	32
33	General Administration	290,392	33
<b>B. Capital Expense</b>			
34	Ownership	63,802	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	40,916	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 741,939	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	60,749	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 60,749	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 Danforth House

# 0030577

Report Period Beginning:

07/01/05

Ending:

06/30/06

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			\$	\$	1
2					2
3	742	832	14,999	18.03	3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11	730	832	15,304	18.39	11
12					12
13					13
14	1,888	2,080	25,442	12.23	14
15					15
16					16
17	1,614	1,774	18,816	10.61	17
18	1,647	1,799	15,744	8.75	18
19					19
20	378	416	15,961	38.37	20
21	1,824	2,080	56,771	27.29	21
22	365	416	7,597	18.26	22
23					23
24	662	742	12,955	17.46	24
25					25
26					26
27					27
28					28
29	590	663	10,839	16.35	29
30	12,300	13,740	134,643	9.80	30
31					31
32					32
33					33
34	22,740	25,374	\$ 329,071 *	\$ 12.97	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	70	\$ 3,201	Ln.1,Col.3	35
36	26	2,600	Ln.9,Col.3	36
37				37
38				38
39	10	900	Ln.10,Col.3	39
40				40
41				41
42				42
43	51	2,315	Ln.10a,Col.3	43
44				44
45				45
46	161	10,465	Ln.10a,Col.3	46
47	48	4,800	Ln.10a,Col.3	47
48	35	1,310	Ln.10,Col.3	48
49	401	\$ 25,591		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53





Facility Name & ID Number Danforth House# 0030577Report Period Beginning: 07/01/05Ending: 06/30/06**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 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. \$ 897 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. \$ 40,916  
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 benefit 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? 26%
- 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?
- 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished yet
- (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 - LINE 7 - OTHERS - GENERAL SERVICES  
 FISCAL YEAR 2006 COST REPORT**

**DANFORTH HOUSE**

<b>Trx Date</b>	<b>Jrnl No.</b>	<b>Orig. Audit Trail</b>	<b>Dist. Reference</b>	<b>Orig. Master Number</b>	<b>Vendor</b>	<b>Amount</b>
08/12/05	130,086	PMTRX00002230	ACCT. #51006	070605DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
08/30/05	131,415	PMTRX00002269	ACCT. #51006	080305DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
09/20/05	133,688	PMTRX00002321	ACCT. #51006	090205DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
10/31/05	139,315	PMTRX00002435	ACCT. #51006	110205DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
11/15/05	139,580	PMTRX00002441	ACCT. #51006	110205DANFORTH-1	ALARM DETECTION SYSTEMS, INC	281.10
01/25/06	147,098	PMTRX00002594	ACCT. #51006	120405DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
01/25/06	147,099	PMTRX00002594	ACCT. #51006	010506DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
02/27/06	149,839	PMTRX00002697	ACCT. #51006	020506DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
03/17/06	152,811	PMTRX00002780	ACCT. #51006	030506DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
04/20/06	156,158	PMTRX00002902	ACCT. #51006	040606DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
05/23/06	159,601	PMTRX00003038	ACCT. #51006	050406DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
06/21/06	162,826	PMTRX00003141	ACCT. #51006	060406DANFORTH	ALARM DETECTION SYSTEMS, INC	281.10
06/30/06	172,009	GLTRX00015603	Realloc. RSD FY2006 exp.		ALARM DETECTION SYSTEMS, INC	84.20
						<b>\$ 3,457.40</b>

**ADA S. MCKINLEY COMMUNITY SERVICES, INC.  
SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION  
FISCAL YEAR 2006 COST REPORT**

**DANFORTH HOUSE**

<b>Trx Date</b>	<b>Jrnl No.</b>	<b>Orig. Audit Trail</b>	<b>Distribution Reference</b>	<b>Vendor</b>	<b>Amount</b>
07/11/05	126,015	PMTRX00002144	LUNCH MEETING	STALLWORTH, PAULETTE	\$ 9.10
07/31/05	129,784	PMTRX00002224	LUNCH FOR MEETING	STALLWORTH, PAULETTE	11.95
08/31/05	134,092	PMTRX00002327	PAYMENT ON ACCOUNT F/AUG. 2005	JEWEL FOOD STORES	7.20
10/31/05	138,002	PMTRX00002418	FOOD F/FOCUS GROUP MTG	WILLIAMS, VALENCIA	8.62
10/31/05	139,538	PMTRX00002439	CATERING	SISTERS' EXOTIC CATERING	67.70
11/30/05	69,661	GLTRX00012062	Variable Allocation - 11/05	HYATT REGENCY MCCORMICK PLACE-CHICAGO	21.03
11/30/05	140,726	PMTRX00002459	ACCT. #6030 3751 0002 9070	PURCHASE ADVANTAGE CARD	8.70
12/21/05	143,264	PMTRX00002514	E.E.A .F/12/05	ALBERT CUELLER, III	7.93
12/28/05	143,765	PMTRX00002525	PTY. CSH. F/12/05	LYDIA M. SIDES-PETTY CASH	13.95
12/30/05	69,661	GLTRX00012398	Variable Allocation - 12/05	HYATT REGENCY MCCORMICK PLACE-CHICAGO	578.07
01/30/06	69,661	GLTRX00012784	Variable Allocation - 01/06	HYATT REGENCY MCCORMICK PLACE-CHICAGO	12.38
01/31/06	147,568	PMTRX00002620	E.E.A. F/01/06	ALBERT CUELLER, III	1.98
01/31/06	149,563	PMTRX00002682	PTY. CSH. F/01/06	DELOIS GLASPER-PETTY CASH	24.25
02/28/06	152,681	PMTRX00002775	ACCT. #6030 3751 0002 9070	PURCHASE ADVANTAGE CARD	14.33
03/24/06	153,341	PMTRX00002799	E.E.A. F/03/06	ALBERT CUELLER, III	0.80
03/29/06	69,661	GLTRX00013544	Variable Allocation - 03/06	HYATT REGENCY MCCORMICK PLACE-CHICAGO	0.92
04/24/06	156,389	PMTRX00002922	E.E.A F/04/06	ALBERT CUELLER, III	2.10
05/18/06	159,311	PMTRX00003027	PTY. CSH. F/05/06	LYDIA M. SIDES-PETTY CASH	12.81
05/31/06	162,202	PMTRX00003121	E.E.A. F/05/06	ALBERT CUELLER, III	6.31
06/30/06	164,667	PMTRX00003180	PTY. CSH. F/06/06	LYDIA M. SIDES-PETTY CASH	17.30
06/30/06	167,262	GLTRX00014985	EXP CK # 75200 - AMEX 01/06	American Express	4.24
06/30/06	167,278	GLTRX00014986	EXP CK # 78734 - AMEX 02/06	American Express	1.66
06/30/06	167,384	GLTRX00014987	EXP CK # 76435 - AMEX 03/06	American Express	3.64
06/30/06	167,398	GLTRX00015116	EXP CK# 78100 - AMEX- 05/06	American Express	7.10
06/30/06	167,405	GLTRX00015117	EXP CK# 78734 - AMEX- 06/06	American Express	1.87
					<b>\$ 845.94</b>



**ADA S. MCKINLEY COMMUNITY SERVICES, INC.  
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION  
FISCAL YEAR 2006 COST REPORT**

**DANFORTH HOUSE**

DESCRIPTION	Amount
Mileage and auto rental	\$ 2,602
Gasoline and vehicle repairs	1,099
Automobile insurance	867
Staff transportation - local	9
	<b>\$ 4,577</b>

**ADA S. McKINLEY COMMUNITY SERVICES, INC.  
 SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION  
 FISCAL YEAR 2006 COST REPORT**

**DANFORTH HOUSE**

DESCRIPTION		Amount
Other Staff Expenses		\$ 234
Client Benefits - Accident Insurance		75
Clothing & personal needs		1,112
Miscellaneous		80
		1,501
Less: Adjustments:		
Clients' Benefits - Accident Insurance	\$ 75	
Clothing & personal needs	1,112	(1,187)
<b>Amount Per Sch. V, Line 27, Col. 8</b>		<b>\$ 314</b>