

Facility Name & ID Number Hammond House

0030619 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	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 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	5,412			5,412	13
14	TOTALS	5,412			5,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.85%

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

61 (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 08/17/86

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 & ID Number Hammond House # 0030619 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
A. General Services											
1	Dietary	22,564	3,034	2,992	28,590		28,590	28,590			1
2	Food Purchase		37,655		37,655		37,655	37,655			2
3	Housekeeping	22,335	1,353		23,688		23,688	23,688			3
4	Laundry		1,230		1,230		1,230	1,230			4
5	Heat and Other Utilities			14,148	14,148		14,148	14,148			5
6	Maintenance	18,816	11,815	13,813	44,444		44,444	44,444			6
7	Other (specify):*			3,738	3,738		3,738	3,738			7
8	TOTAL General Services	63,715	55,087	34,691	153,493		153,493	153,493			8
B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600	2,600			9
10	Nursing and Medical Records	167,403	8,951	2,635	178,989		178,989	(1,735)	177,254		10
10a	Therapy			17,580	17,580		17,580	17,580			10a
11	Activities		7	5,078	5,085		5,085	5,085			11
12	Social Services	15,304			15,304		15,304	15,304			12
13	CNA Training		280	153	433		433	433			13
14	Program Transportation			1,931	1,931		1,931	1,931			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	182,707	9,238	29,977	221,922		221,922	(1,735)	220,187		16
C. General Administration											
17	Administrative	81,552		60,083	141,635		141,635	141,635			17
18	Directors Fees										18
19	Professional Services			8,595	8,595		8,595	8,595			19
20	Dues, Fees, Subscriptions & Promotions			3,653	3,653		3,653	3,653			20
21	Clerical & General Office Expenses	12,955	5,421	8,774	27,150		27,150	27,150			21
22	Employee Benefits & Payroll Taxes			92,844	92,844		92,844	92,844			22
23	Inservice Training & Education			823	823		823	823			23
24	Travel and Seminar			3,136	3,136		3,136	(2,090)	1,046		24
25	Other Admin. Staff Transportation			5,568	5,568		5,568	5,568			25
26	Insurance-Prop.Liab.Malpractice			5,050	5,050		5,050	5,050			26
27	Other (specify):*			1,056	1,056		1,056	(390)	666		27
28	TOTAL General Administration	94,507	5,421	189,582	289,510		289,510	(2,480)	287,030		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	340,929	69,746	254,250	664,925		664,925	(4,215)	660,710		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Hammond House

#0030619

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	
	D. Ownership											
30	Depreciation			19,828	19,828		19,828	(2,244)	17,584			30
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	TOTAL Ownership			64,889	64,889		64,889	(2,244)	62,645			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			38,624	38,624		38,624		38,624			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,624	38,624		38,624		38,624			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	340,929	69,746	357,763	768,438		768,438	(6,459)	761,979			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 Hammond House

0030619

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 Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(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)	(390)	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)	\$ (2,634)		\$	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))	\$ (2,634)		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

Hammond House

ID# 0030619

Report Period Beginning: 07/01/05

Ending: 06/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	(1,735)	10	12
13	Out-of-Town Travel	(2,090)	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	(3,825)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hammond House# 0030619

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,735)	0	0	0	0	0	0	0	0	0	0	(1,735)	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	(1,735)	0	0	0	0	0	0	0	0	0	0	(1,735)	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	(2,090)	0	0	0	0	0	0	0	0	0	0	(2,090)	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):*	(390)	0	0	0	0	0	0	0	0	0	0	(390)	27
28	TOTAL General Administration	(2,480)	0	0	0	0	0	0	0	0	0	0	(2,480)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,215)	0	0	0	0	0	0	0	0	0	0	(4,215)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Hammond House**

0030619

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

	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	(2,244)	0	0	0	0	0	0	0	0	0	0	(2,244)	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	(2,244)	0	0	0	0	0	0	0	0	0	0	(2,244)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(6,459)	0	0	0	0	0	0	0	0	0	0	(6,459)	45

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	Chicago, IL
		Davis House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Chicago, IL
		Knight House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Chicago, IL
		Danforth House	Chicago, IL	Ada S. Mckinley	Chicago, IL	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		\$			\$	\$	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 Hammond House # 0030619 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 **Hammond House**

0030619 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	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	35,045,209	101	\$ 3,063,193	\$ 1,637,173	669,913	\$ 58,555	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,045,209	101	79,921		669,913	1,528	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					\$ 3,143,114	\$ 1,637,173		\$ 60,083	25

Facility Name & ID Number **Hammond House** # **0030619** 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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	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								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$2,657.00		\$ 334,060	\$ 280,721			\$ 26,253	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	\$ 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.)

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 Hammond House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030619

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	<u>Tax</u> <u>Applicable to</u> <u>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 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 hom (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 20C 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 Hammond House
 X. BUILDING AND GENERAL INFORMATION:

0030619 Report Period Beginning: 07/01/05 Ending: 06/30/06

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ICF/DD		1984	\$ 19,952	1
2					2
3	TOTALS			\$ 19,952	3

Facility Name & ID Number Hammond House

0030619

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	4
5				1988	8,618	344	25	287	(57)	6,548	5
6				1999	13,000	1,300	10	1,300		9,750	6
7											7
8											8
	Improvement Type**										
9		Roof and gutter replacements		2002	10,460	1,046	10	1,046		4,358	9
10		70,000 BTU furnace		2004	2,165	433	5	433		1,137	10
11		Interior repainting, kitchen, dining room, washroom, laundry room, and bathroom repairs		2004	13,600	1,360	10	1,360		3,230	11
12		Upflow Bryant furnace		2005	2,495	499	5	499		853	12
13		Goodman 5-ton furnace		2005	2,550	510	5	510		914	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

*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)		\$ 380,928	\$ 18,614		\$ 16,370	\$ (2,244)	\$ 282,662	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	\$ 5,588	\$ 965	\$ 965	\$	5 Years	\$ 3,450	71
72	Current Year Purchases	1,244	249	249		5 Years	249	72
73	Fully Depreciated Assets	26,032					26,032	73
74								74
75	TOTALS	\$ 32,864	\$ 1,214	\$ 1,214	\$		\$ 29,731	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	2	
	Reference	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)	\$ 433,744	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,828	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,584	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)	\$ 312,393	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? _____

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

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 \$ _____

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? _____

16. 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>358.17</u>	\$ <u>4,298</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>358.17</u>	\$ <u>4,298</u>	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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>40</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>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1			2			3			4		
		Facility											
		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				153						153		
8	CNA Competency Tests												
9	TOTALS	\$		\$	433	\$		\$		\$	433		
10	SUM OF line 9, col. 1 and 2 (e)	\$	433										

- (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)	
TOTAL TRAINED	1

- (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 & ID Number Hammond House

0030619

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*	
A. Current Assets			
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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,952,600	10
B. Long-Term Assets			
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 Cos	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,748,576	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,701,176	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
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
Other Current Liabilities(specify):			
36	<u>Unfunded Pension Liability</u>	128,990	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,808,382	38
D. Long-Term Liabilities			
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
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,074,016	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,882,398	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,818,778	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,701,176	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (261,675)	1
2	Restatements (describe):		2
3	Beginning Balance, Other Operating Units	4,796,028	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,534,353	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	3,914	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) <u>Operating Income-Other Operating Units</u>	280,511	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 284,425	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)	\$ 4,818,778	24 *

* This must agree with page 17, line 47.

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	\$ 665,205	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 665,205	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	104,970	10
11	CNA Training Reimbursements	1,975	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		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)	\$ 106,945	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Proceeds, Jury Duty	202	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 202	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 772,352	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	153,493	31
32	Health Care	221,922	32
33	General Administration	289,510	33
B. Capital Expense			
34	Ownership	64,889	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,624	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 768,438	40
41	Income before Income Taxes (line 30 minus line 40)**	3,914	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,914	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	742	14,999	18.03	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	730	15,304	18.39	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,824	22,564	10.85	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	1,614	18,816	10.61	17
18	Housekeepers	1,824	22,335	10.74	18
19	Laundry				19
20	Administrator	378	15,960	38.37	20
21	Assistant Administrator	1,824	47,155	22.67	21
22	Other Administrative	365	7,597	18.26	22
23	Office Manager				23
24	Clerical	662	12,955	17.46	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	590	10,839	16.35	29
30	Habilitation Aides (DD Homes)	13,097	152,405	10.42	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	23,650	340,929 *	12.85	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	66 \$ 2,992	Ln.1,Col.3	35
36	Medical Director	26 2,600	Ln.9,Col.3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	10 900	Ln.10,Col.3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	51 2,315	Ln.10a,Col.3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psychologist</u>	161 10,465	Ln.10a,Col.3	46
47	<u>Psychiatrist</u>	48 4,800	Ln.10a,Col.3	47
48	<u>Dental</u>	46 1,735	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	408 \$ 25,807		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hammond House# 0030619Report 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. \$ 116 Line _____
- (7) Have all costs reported on this form been determined using accounting procedure 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 _____ NO X
- (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. \$ 38,624
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? 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 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

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Orig. Master Number	Vendor	Amount
08/05/05	128,424	PMTRX00002206	ACCT. #51009	070605HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
08/17/05	130,278	PMTRX00002238	ACCT. #51009	080305HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
11/02/05	137,583	PMTRX00002411	ACCT. #51009	51009-1093	ALARM DETECTION SYSTEMS, INC.	281.10
11/15/05	139,546	PMTRX00002440	ACCT. #51009	110205HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
01/25/06	147,102	PMTRX00002594	ACCT. #51009	120405HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
01/25/06	147,103	PMTRX00002594	ACCT. #51009	010506HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
01/25/06	147,104	PMTRX00002594	ACCT. #51008	120405KNIGHT	ALARM DETECTION SYSTEMS, INC.	281.10
01/25/06	147,105	PMTRX00002594	ACCT. #51008	010506KNIGHT	ALARM DETECTION SYSTEMS, INC.	281.10
02/27/06	149,842	PMTRX00002697	ACCT. #51009	020506HAMMOND HSE	ALARM DETECTION SYSTEMS, INC.	281.10
03/20/06	152,793	PMTRX00002779	ACCT. #51009	030506HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
04/20/06	156,155	PMTRX00002902	ACCT. #51009	040606HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
05/23/06	159,598	PMTRX00003038	ACCT. #51009	050406HAMMOND	ALARM DETECTION SYSTEMS, INC.	281.10
06/21/06	162,823	PMTRX00003141	ACCT. #51009	060406HAMMOND HSE	ALARM DETECTION SYSTEMS, INC.	281.10
06/30/06	172,009	GLTRX00015603	Realloc. RSD FY2006 exp.		ALARM DETECTION SYSTEMS, INC.	84.18
						\$ 3,738.48

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

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Distribution Reference	Vendor	Amount
07/11/05	126,015	PMTRX00002144	LUNCH MEETING	STALLWORTH, PAULETTE	\$ 9.13
07/31/05	129,784	PMTRX00002224	LUNCH FOR MEETING	STALLWORTH, PAULETTE	11.94
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	20.64
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	584.10
01/30/06	69,661	GLTRX00012784	Variable Allocation - 01/06	HYATT REGENCY MCCORMICK PLACE-CHICAGO	8.47
01/31/06	147,568	PMTRX00002620	E.E.A. F/01/06	ALBERT CUELLER, III	1.98
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	0.89
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
					\$ 823.41

ADA S .MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V, LINE 24, COLUMN 8 - ANALYSIS OF IN-STATE TRAVEL AND SEMINAR
FOR THE FISCAL YEAR ENDED JUNE 30, 2006

HAMMOND HOUSE

DATE	CHECK NO.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	In-State Travel & Seminar
07/11/05	125.826	69999	ELDER RIGHTS CONFERENCE	19th Annual Elder Rights Conference	Schaumburg, IL	Gwendolyn Ellis	Service Coordinator	July 19-21, 2005		\$ 5.51
07/31/05	131.131	71190	HILTON SPRINGFIELD	HOTEL-IARF CONFERENCE	Springfield, IL	Linda Darling	Director - Habilitation Services	September 27-29, 2005	IARF/ICAN	48.69
08/24/05	131.080	71163	I.C.A.N., INC.	IARF CONFERENCE	Springfield, IL	Linda Darling	Director - Habilitation Services	September 27-29, 2005	IARF/ICAN	71.25
10/21/05	136.942	72496	Great Lakes Center	202/811 Construction Conference	Chicago, IL	Albert Cueller, III	Division Director	December 5-7, 2005	Ada S. McKinley	15.00
12/21/05	143.215	73926	I.C.A.N., INC.	IARF/ICAN Conference	Springfield, IL	Albert Cueller, III	Division Director	September 27-29, 2005	IARF/ICAN	136.01
01/06/06	144.137	74164	ARC OF ILLINOIS	SEMINAR F/L DARLING	Lisle, IL	Linda Darling	Director - Habilitation Services	February 9-10, 2006	The ARC of Illinois	44.00
01/06/06	144.139	74169	HILTON HOTEL	ARC CONFERENCE F/L DARLING	Lisle, IL	Linda Darling	Director - Habilitation Services	February 9-10, 2006	The ARC of Illinois	35.52
01/18/06	146.323	74401	ARC OF ILLINOIS	QMRP LEADERSHIP CONFERENCE	Homewood, IL	Angela Moore	Center Director	January 24, 2006	The ARC of Illinois	90.00
02/28/06	151.027	75329	Lorman Educ. Sv	Understanding the Bidding & Construction Process in Illinois	Chicago, IL	Albert Cueller, III	Division Director	March 30, 2006	Ada S. McKinley	223.47
03/28/06	153.479	76123	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	IASC 2006 Training Conference	East St. Louis, IL	Linda Darling	Director - Habilitation Services	May 3-5, 2006	IASC	36.00
03/28/06	153.480	76092	CASINO QUEEN HOTEL	IASC 2006 Training Conference	East St. Louis, IL	Linda Darling	Director - Habilitation Services	May 3-5, 2006	IASC	177.07
03/31/06	153.797	76271	2006 MENTAL HEALTH & AGING CONFERENCE	Mental Health & Aging Conference	Schaumburg, IL	L. Darling, G. Ellis, P. Halliburton	Dir.-Hab. Svcs., Svc. Coords.	April 20-21, 2006	IL Dept. of Aging	87.38
03/31/06	155.485	68533	Holiday Inn Select	HUD Conference	Decatur, IL	Linda Darling	Director - Habilitation Services		HUD	76.49
	TOTAL HAMMOND HOUSE									\$ 1,046.39

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

HAMMOND HOUSE

DESCRIPTION	
Mileage and auto rental	\$ 3,593
Gasoline and vehicle repairs	1,107
Automobile insurance	867
Staff transportation - local	1
	\$ 5,568

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

HAMMOND HOUSE

DESCRIPTION		
Other Staff Expenses		\$ 586
Client Benefits - Accident Insurance		75
Clothing & personal needs		315
Miscellaneous		80
		1,056
Less: Adjustments:		
Clients' Benefits - Accident Insurance	\$ 75	
Clothing & personal needs	315	(390)
Amount Per Sch. V, Line 27, Col. 8		\$ 666