

Facility Name & ID Number Davis House

0030585 Report Period Beginning: 07/01/06 Ending: 06/30/07

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 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,934			4,934	13
14	TOTALS	4,934			4,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.12%

D. How many bed-hold days during this year were paid by the Department? 285 (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 11/03/86

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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 06/30/07

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

Facility Name & ID Number

Davis House

#

0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	23,578	3,374	3,052	30,004		30,004		30,004		1
2	Food Purchase		33,528		33,528		33,528		33,528		2
3	Housekeeping		653		653		653		653		3
4	Laundry		3,632		3,632		3,632		3,632		4
5	Heat and Other Utilities			12,164	12,164		12,164		12,164		5
6	Maintenance	20,753	12,860	16,129	49,742		49,742		49,742		6
7	Other (specify):*			1,089	1,089		1,089		1,089		7
8	TOTAL General Services	44,331	54,047	32,434	130,812		130,812		130,812		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	191,137	5,662	1,440	198,239		198,239	(425)	197,814		10
10a	Therapy			21,480	21,480		21,480		21,480		10a
11	Activities		139	6,697	6,836		6,836		6,836		11
12	Social Services	15,134			15,134		15,134		15,134		12
13	CNA Training		521	293	814		814		814		13
14	Program Transportation			2,240	2,240		2,240		2,240		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	206,271	6,322	34,550	247,143		247,143	(425)	246,718		16
	C. General Administration										
17	Administrative	88,019		66,593	154,612		154,612		154,612		17
18	Directors Fees										18
19	Professional Services			7,857	7,857		7,857		7,857		19
20	Dues, Fees, Subscriptions & Promotions			3,399	3,399		3,399		3,399		20
21	Clerical & General Office Expenses	9,340	5,707	6,971	22,018		22,018		22,018		21
22	Employee Benefits & Payroll Taxes			92,067	92,067		92,067		92,067		22
23	Inservice Training & Education			1,049	1,049		1,049		1,049		23
24	Travel and Seminar			4,276	4,276		4,276	(2,515)	1,761		24
25	Other Admin. Staff Transportation			5,281	5,281		5,281		5,281		25
26	Insurance-Prop.Liab.Malpractice			5,438	5,438		5,438		5,438		26
27	Other (specify):*			21,223	21,223		21,223	(20,953)	270		27
28	TOTAL General Administration	97,359	5,707	214,154	317,220		317,220	(23,468)	293,752		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	347,961	66,076	281,138	695,175		695,175	(23,893)	671,282		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 Davis House

#0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			19,385	19,385		19,385	(2,244)	17,141			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,709	25,709		25,709		25,709			32
33	Real Estate Taxes			1,031	1,031		1,031		1,031			33
34	Rent-Facility & Grounds			11,316	11,316		11,316		11,316			34
35	Rent-Equipment & Vehicles			7,169	7,169		7,169		7,169			35
36	Other (specify):*											36
37	TOTAL Ownership			64,610	64,610		64,610	(2,244)	62,366			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			37,012	37,012		37,012		37,012			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,012	37,012		37,012		37,012			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	347,961	66,076	382,760	796,797		796,797	(26,137)	770,660			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 Davis House

0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(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)	(953)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,000)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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)	\$ (23,197)		\$	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))	\$ (23,197)		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.

		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

Davis House

ID# 0030585

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	(425)	10	12
13	Out-of-Town Travel	(2,515)	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	(2,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Davis House# 0030585 Report Period Beginning:07/01/06Ending: 06/30/07

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	(425)	0	0	0	0	0	0	0	0	0	0	(425)	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	(425)	0	0	0	0	0	0	0	0	0	0	(425)	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	(2,515)	0	0	0	0	0	0	0	0	0	0	(2,515)	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):*	(20,953)	0	0	0	0	0	0	0	0	0	0	(20,953)	27
28	TOTAL General Administration	(23,468)	0	0	0	0	0	0	0	0	0	0	(23,468)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,893)	0	0	0	0	0	0	0	0	0	0	(23,893)	29

STATE OF ILLINOIS

Facility Name & ID Number Davis House# 0030585 Report Period Beginning:07/01/06 Ending: 06/30/07 Summary B

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)	(26,137)	0	0	0	0	0	0	0	0	0	0	(26,137) 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	Voluntary Health
		Hammond House	Chicago, IL	Ada S. Mckinley	Chicago, IL	and Welfare
		Knight House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Agency
		Danforth House	Chicago, IL	Ada S. Mckinley	Chicago, IL	

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	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.

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 Davis House # 0030585 Report Period Beginning: 07/01/06 Ending: 06/30/07

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	<u>Ln. 17</u>	<u>Central Administration Exp.</u>	<u>Direct Cost</u>	<u>35,662,076</u>	<u>108</u>	<u>\$ 3,260,926</u>	<u>\$ 1,763,619</u>	<u>\$ 64,997</u>	<u>1</u>
2	<u>Ln. 17</u>	<u>Central Administration Exp.</u>	<u>Direct Cost</u>	<u>35,662,076</u>	<u>108</u>	<u>80,058</u>	<u>710,819</u>	<u>1,596</u>	<u>2</u>
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					\$ 3,340,984	\$ 1,763,619	\$ 66,593	25

Facility Name & ID Number Davis House # 0030585 Report Period Beginning: 07/01/06 Ending: 06/30/07

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
		YES	NO				Original	Balance				
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		
A. Directly Facility Related												
Long-Term												
1	H.U.D.		X	Mortgage	\$2,657.00	12/01/86	\$ 334,060	\$ 274,549	12/1/2027	0.0925	\$ 25,709	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	\$ 274,549			\$ 25,709	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	\$ 274,549			\$ 25,709	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.)

Facility Name & ID Number **Davis House**

0030585 Report Period Beginning: **07/01/06** Ending: **06/30/07**

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

B. Real Estate Taxes

<p>Important, 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 2006 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 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Davis House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030585

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 2006 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 2006

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

B. Real Estate Tax Cost Allocation:

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2007

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 Davis House

0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>ICF/DD</u>		<u>1984</u>	<u>\$ 18,658</u>	<u>1</u>
2	<u>Vacant</u>		<u>1990</u>	<u>7,524</u>	<u>2</u>
3	TOTALS			\$ 26,182	3

Facility Name & ID Number Davis House

0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

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)	\$ 268,993
5			1988	8,618	344	25	287	(57)	6,894
6			1999	13,000	1,300	10	1,300		11,050
7									
8									
Improvement Type**									
9	Roof and gutter replacements		2002	10,460	1,046	10	1,046		5,405
10	Repainting of hallways and dining, laundry room, bathroom								
11	and kitchen repairs		2004	14,500	1,450	10	1,450		4,773
12	Rheem 10 gal. hot water tank		2005	5,611	1,123	5	1,123		2,665
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

Facility Name & ID Number Davis House

0030585

Report Period Beginning:

07/01/06

Ending:

06/30/07

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)	\$ 380,229	\$ 18,385		\$ 16,141	\$ (2,244)	\$ 299,780	70

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

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	\$ 5,832	\$ 1,000	\$ 1,000	\$	5 Years	\$ 4,342	71
72	Current Year Purchases					5 Years		72
73	Fully Depreciated Assets	39,564					39,564	73
74								74
75	TOTALS	\$ 45,396	\$ 1,000	\$ 1,000	\$		\$ 43,906	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 451,807	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,385	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,141	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)	\$ 343,686	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
 ** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 11,316			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 11,316			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 NO

16. Rental Amount for movable equipment: \$ 3,275 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	Staff transportation	2006 Toyota Sienna	\$ 324.52	\$ 3,894	17
18					18
19					19
20					20
21	TOTAL		\$ 324.52	\$ 3,894	21

10. Effective dates of current rental agreement:

Beginning 07/01/06
Ending 06/30/07

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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		521		521
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments		293		293
8 CNA Competency Tests				
9 TOTALS	\$	\$ 814	\$	\$ 814
10 SUM OF line 9, col. 1 and 2 (e)	\$	814		

- (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.

\$ N/A

D. NUMBER OF CNAs TRAINED

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

- (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 Davis House

0030585

Report Period Beginning: 07/01/06

Ending:

06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(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	\$	\$ 1,688,546	1
2	Cash-Patient Deposits		130,249	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 196,349)		5,337,450	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		142,242	6
7	Other Prepaid Expenses		111,139	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 7,409,626	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		710,587	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,192,816	14
15	Leasehold Improvements, at Historical Cost		1,955,344	15
16	Equipment, at Historical Cost		4,356,477	16
17	Accumulated Depreciation (book methods)		(9,577,404)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		399,160	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Issue Costs, Security Deposits</u>		105,043	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 6,097,522	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 13,507,148	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 2,059,872	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		131,244	28
29	Short-Term Notes Payable		6,958	29
30	Accrued Salaries Payable		2,099,694	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		26,568	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		127,571	35
Other Current Liabilities(specify):				
36	<u>Unfunded Pension Liability</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 4,451,907	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		19,802	39
40	Mortgage Payable		1,871,605	40
41	Bonds Payable		1,480,000	41
42	Deferred Compensation		777,327	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,148,734	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 8,600,641	46
47	TOTAL EQUITY(page 18, line 24)	\$	\$ 4,906,507	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	\$ 13,507,148	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (272,941)	1
2	Restatements (describe):		2
3	Beginning Balance, Other Operating Units	5,091,719	3
4	Prior Year's Adjustments	138,177	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,956,955	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(36,510)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Operating Income-Other Operating Units	(13,938)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (50,448)	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)	\$ 4,906,507	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Davis House

0030585

Report Period Beginning: 07/01/06

Ending: 06/30/07

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	\$ 644,026	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 644,026	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	111,701	10
11	CNA Training Reimbursements	4,051	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 115,752	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	509	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 509	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 760,287	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	130,812	31
32	Health Care	247,143	32
33	General Administration	317,220	33
B. Capital Expense			
34	Ownership	64,610	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,012	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 796,797	40
41	Income before Income Taxes (line 30 minus line 40)**	(36,510)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (36,510)	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 Davis House

0030585

Report Period Beginning: 07/01/06

Ending:

06/30/07

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	520	582	15,215	26.14	3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11	365	416	15,134	36.38	11
12					12
13					13
14	1,824	2,080	23,578	11.34	14
15					15
16					16
17	1,453	1,640	20,753	12.65	17
18					18
19					19
20	322	354	15,908	44.94	20
21	1,824	2,080	51,129	24.58	21
22	255	291	7,437	25.56	22
23					23
24	563	634	9,340	14.73	24
25					25
26					26
27					27
28					28
29	724	811	13,545	16.70	29
30	15,219	17,190	175,922	10.23	30
31					31
32					32
33					33
34	23,069	26,078	\$ 347,961 *	\$ 13.34	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		\$ 3,052	Ln.1,Col.3	35
36		2,400	Ln.9,Col.3	36
37				37
38				38
39		1,015	Ln.10,Col.3	39
40				40
41				41
42				42
43		2,305	Ln.10a,Col.3	43
44				44
45				45
46		14,375	Ln.10a,Col.3	46
47		4,800	Ln.10a,Col.3	47
48		425	Ln.10,Col.3	48
49		\$ 28,372		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 Davis House# 0030585Report Period Beginning: 07/01/06Ending: 06/30/07**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. \$ 0 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. \$ 37,012
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? 30%
- 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 2007 COST REPORT**

DAVIS HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/26/06	167,090	PMTRX00003264	Purchases	ALARM DETECTION SYSTEMS, INC.	\$ 281.10
07/31/06	168,891	PMTRX00003309	Purchases	CUELLER, ALBERT III	17.50
09/08/06	171,475	PMTRX00003365	Purchases	ALARM DETECTION SYSTEMS, INC.	21.72
09/08/06	171,478	PMTRX00003365	Purchases	ALARM DETECTION SYSTEMS, INC.	281.10
11/10/06	178,033	PMTRX00003507	Purchases	ALARM DETECTION SYSTEMS, INC.	281.10
11/20/06	179,244	PMTRX00003527	Purchases	ALARM DETECTION SYSTEMS, INC.	21.73
12/31/06	183,514	PMTRX00003618	Purchases	ALARM DETECTION SYSTEMS, INC.	2.31
02/27/07	189,403	PMTRX00003728	Purchases	ALARM DETECTION SYSTEMS, INC.	23.19
05/21/07	199,693	PMTRX00003941	Purchases	ALARM DETECTION SYSTEMS, INC.	23.19
05/31/07	201,920	PMTRX00004000	Purchases	HOUSTON & ASSOCIATES PROTECTIVE	136.00
					\$ 1,088.94

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, 2007

DAVIS HOUSE

DATE	CHECK NO.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	In-State Travel & Seminar
07/31/06	169.653	78815	Holiday Inn Skokie North Shore		Skokie, IL	Paulette Stallworth	Staff Training Coordinator	July 11-12, 2006	Ada S. McKinley	30.36
11/06/06	177.688	81979	RESCORSOFT, INC.	ProCor Training	Elk Grove Village, IL	Pamela Halliburton & Gwendolyn Ellis	Service Coordinators	November 15, 2006	Ada S. McKinley	94.21
10/31/06	178.619	80757	Crown Plaza	IARF Conference	Springfield, IL	Evalynn Beavers	Center Director	October 17-19, 2006	IARF	267.96
10/31/06	179.055	79834	AmEx	Education Conference	Springfield, IL	Albert Cueller III	Division Director	July 24-25, 2006	Ada S. McKinley	69.05
11/30/06	181.924	81979	Rescorsoft	ProCor Training	Elk Grove Village, IL	Linda Darling	Director-Habilitation Services	November 15, 2006	Ada S. McKinley	55.63
12/31/06	183.525	83429	ARC OF ILLINOIS	QMRP Leadership	Alsip, IL	Evalynn Beavers	Center Director	January 23, 2007	Tha ARC of Illinois	90.00
12/31/06	183.525	83429	ARC OF ILLINOIS	QMRP Leadership	Alsip, IL	Linda Darling	Director-Habilitation Services	January 23, 2007	Tha ARC of Illinois	18.00
01/11/07	184.551	83494	ARC OF ILLINOIS	ICEARC Leadership Conference	Lisle, IL	Linda Darling	Director-Habilitation Services	February 1-2, 2007	Tha ARC of Illinois	60.85
01/11/07	184.553	83496	HILTON HOTEL	ICEARC Leadership Conference	Lisle, IL	Linda Darling	Director-Habilitation Services	February 1-2, 2007	Tha ARC of Illinois	35.52
01/26/07	186.536	84312	I.C.A.N., INC.	ICAN Conference	Springfield, IL	Albert Cueller III	Division Director	August 31, 2006	ICAN	58.06
01/26/07	186.536	84312	I.C.A.N., INC.	ICAN Conference	Springfield, IL	Evalynn Beavers	Center Director	August 31, 2006	ICAN	303.03
01/26/07	186.537	84312	I.C.A.N., INC.	ICAN Conference	Springfield, IL	Linda Darling	Director-Habilitation Services	August 31, 2006	ICAN	4.00
02/13/07	188.169	84666	AAMR, ILLINOIS CHAPTER	AID 38th Annual Conference	Naperville, IL	Linda Darling	Director-Habilitation Services	March 15, 2007	Assoc. for Indiv. Devt.	28.00
03/08/07	190.610	85217	ARC OF ILLINOIS	The Autism Program Convention	Lisle, IL	Linda Darling	Director-Habilitation Services	April 25-26, 2007	Tha ARC of Illinois	69.46
03/08/07	190.615	85221	HILTON HOTEL	The Autism Program Convention	Lisle, IL	Linda Darling	Director-Habilitation Services	April 25-26, 2007	Tha ARC of Illinois	45.29
02/28/07	192.197	81734	Claudia Boose	Lay Responder First Aid & CPR/AED Instructor Update	Chicago, IL	Claudia Boose	Health Services Coordinator	November 3, 2006	American Red Cross	10.50
02/28/07	192.199	80757	Crown Plaza	IARF Conference	Springfield, IL	Linda Darling	Director-Habilitation Services	October 17-19, 2006	IARF	154.46
03/19/07	192.270	85696	CROWN PLAZA	IL Assn. of Svc. Coord. 2007 Training Conference	Springfield, IL	Pamela Halliburton & Gwendolyn Ellis	Service Coordinators	May 7-9, 2007	IL Assoc. of Svc. Coord.	80.03
03/19/07	192.288	85708	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS	IL Assn. of Svc. Coord. 2007 Training Conference	Springfield, IL	Pamela Halliburton & Gwendolyn Ellis	Service Coordinators	May 7-9, 2007	IL Assoc. of Svc. Coord.	40.00
03/31/07	194.550	86262	CLAUDIA BOOSE	Medication Review	Chicago, IL	Claudia Boose	Health Services Coordinator	March 21, 2007	Ada S. McKinley	2.10
03/31/07	194.558	86291	DORIS ENGLISH	Medication Review	Chicago, IL	Doris English	Registered Nurse	March 21, 2007	Ada S. McKinley	2.10
04/30/07	196.375	86797	CAREER TRACK	Managing the Front Desk	Merrillville, IN	Naomi Chase	Receptionist/Typist	May 16, 2007	CareerTrack	14.80
04/30/07	198.605	85015	Lorman Educational Services	Building Codes Seminar	Chicago, IL	Wayne Ekl	Chief Engineer/Maint. Supervisor	April 13, 2007	Ada S. McKinley	46.06
06/26/07	203.560	88438	EVALYNN BEAVERS-PETTY CASH	Medical Conference	Elgin, IL	Evalynn Beavers	Center Director	May 24, 2007	Dept. of Public Health	22.08
06/30/07	206.711	83507	AmEx	Education Conference	Springfield, IL	Albert Cueller III	Division Director	December 13-15, 2006	Ada S. McKinley	101.18
06/30/07	207.040	87090	AmEx	Education Conference	Springfield, IL	Albert Cueller III	Division Director	April 25-27, 2007	Ada S. McKinley	57.93
			TOTAL DAVIS HOUSE							\$ 1,760.66

**ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2007 COST REPORT**

DAVIS HOUSE

DESCRIPTION	Amount
Mileage and auto rental	\$ 2,839
Gasoline and vehicle repairs	1,600
Automobile insurance	842
	\$ 5,281

**ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2007 COST REPORT**

DAVIS HOUSE

DESCRIPTION	Amount
Other Staff Expenses	\$ 162
Client Benefits - Accident Insurance	108.00
Clothing & personal needs	953
Miscellaneous	20,000
	\$ 21,223