

Facility Name & ID Number Hammond House# 0030619 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	
		Medicaid Recipient	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	5,208			5,208	13
14	TOTALS	5,208			5,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.12%D. How many bed-hold days during this year were paid by the Department? 160 (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/AF. Does the facility maintain a daily midnight census? YesG. 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 08/17/86J. 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: 06/30/07
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Hammond House # 0030619 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
1	A. General Services										
1	Dietary	5,014	4,585	3,064	12,663		12,663		12,663		1
2	Food Purchase		34,413		34,413		34,413		34,413		2
3	Housekeeping	24,394	757		25,151		25,151		25,151		3
4	Laundry		1,069		1,069		1,069		1,069		4
5	Heat and Other Utilities			14,262	14,262		14,262		14,262		5
6	Maintenance	20,753	12,204	16,025	48,982		48,982		48,982		6
7	Other (specify):*			1,241	1,241		1,241		1,241		7
8	TOTAL General Services	50,161	53,028	34,592	137,781		137,781		137,781		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	179,030	11,240	3,915	194,185		194,185	(2,900)	191,285		10
10a	Therapy			21,479	21,479		21,479		21,479		10a
11	Activities		109	6,134	6,243		6,243		6,243		11
12	Social Services	15,134			15,134		15,134		15,134		12
13	CNA Training		521	234	755		755		755		13
14	Program Transportation			2,400	2,400		2,400		2,400		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	194,164	11,870	36,562	242,596		242,596	(2,900)	239,696		16
	C. General Administration										
17	Administrative	82,828		63,468	146,296		146,296		146,296		17
18	Directors Fees										18
19	Professional Services			3,227	3,227		3,227		3,227		19
20	Dues, Fees, Subscriptions & Promotions			3,249	3,249		3,249		3,249		20
21	Clerical & General Office Expenses	9,340	5,780	7,301	22,421		22,421		22,421		21
22	Employee Benefits & Payroll Taxes			85,114	85,114		85,114		85,114		22
23	Inservice Training & Education			1,066	1,066		1,066		1,066		23
24	Travel and Seminar			2,778	2,778		2,778	(1,501)	1,277		24
25	Other Admin. Staff Transportation			6,237	6,237		6,237		6,237		25
26	Insurance-Prop.Liab.Malpractice			5,202	5,202		5,202		5,202		26
27	Other (specify):*			1,295	1,295		1,295	(967)	328		27
28	TOTAL General Administration	92,168	5,780	178,937	276,885		276,885	(2,468)	274,417		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	336,493	70,678	250,091	657,262		657,262	(5,368)	651,894		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			19,733	19,733		19,733	(2,244)	17,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,709	25,709		25,709		25,709			32
33	Real Estate Taxes											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			63,927	63,927		63,927	(2,244)	61,683			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			39,476	39,476		39,476		39,476			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			39,476	39,476		39,476		39,476			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	336,493	70,678	353,494	760,665		760,665	(7,612)	753,053			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: 07/01/06

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)	(967)	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 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)	\$ (3,211)		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (3,211)		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: 07/01/06
 Ending: 06/30/07

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	(2,900)	10	12
13	Out-of-Town Travel	(1,501)	24	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,401)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hammond House

0030619

Report Period Beginning:

07/01/06

Ending:

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	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	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	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	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	(1,501)	0	0	0	0	0	0	0	0	0	0	(1,501)	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):*	(967)	0	0	0	0	0	0	0	0	0	0	(967)	27
28	TOTAL General Administration	(2,468)	0	0	0	0	0	0	0	0	0	0	(2,468)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,368)	0	0	0	0	0	0	0	0	0	0	(5,368)	29

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
		Davis House	Chicago, IL	Ada S. Mckinley	Chicago, IL	and Welfare
		Knight House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Agency
		Danforth House	Chicago, IL	Ada S. Mckinley	Chicago, IL	

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

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

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

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/06 Ending: 06/30/07

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: 07/01/06 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	Ln. 17	Central Administration Exp.	Direct Cost	35,662,076	108	\$ 3,260,926	\$ 1,763,619	\$ 61,947	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,662,076	108	80,058	677,464	1,521	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					\$ 3,340,984	\$ 1,763,619	\$ 63,468	25

Facility Name & ID Number Hammond House # 0030619 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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	H.U.D.		X	Mortgage	\$2,657.00	12/01/86	\$ 334,060	\$ 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.)

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:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		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
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 Hammond House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030619

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 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 Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 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 Hammond House

0030619 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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Hammond House

0030619

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	4
5			1988	8,618	344	25	287	(57)	6,894	5
6			1999	13,000	1,300	10	1,300		11,050	6
7										7
8										8
Improvement Type**										
9	Roof and gutter replacements		2002	10,460	1,046	10	1,046		5,404	9
10	70,000 BTU furnace		2004	2,165	433	5	433		1,570	10
11	Interior repainting, kitchen, dining room, washroom									11
12	laundry room, and bathroom repairs		2004	13,600	1,360	10	1,360		4,590	12
13	Upflow Bryant furnace		2005	2,495	499	5	499		1,351	13
14	Goodman 5-ton furnace		2005	2,550	510	5	510		1,424	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

Facility Name & ID Number Hammond House

0030619

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)	\$	380,928	\$	18,614	\$	16,370	\$	(2,244)	\$	301,276	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	\$ 1,001	\$ 1,001	\$	5 Years	\$ 4,342	71
72	Current Year Purchases	2,022	118	118		5 Years	118	72
73	Fully Depreciated Assets	34,080					34,080	73
74								74
75	TOTALS	\$ 41,934	\$ 1,119	\$ 1,119	\$		\$ 38,540	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)	\$ 442,814	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,733	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,489	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)	\$ 339,816	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>11,316</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>11,316</u>			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	<u>Staff transportation</u>	<u>2006 Toyota Sienna</u>	\$ <u>324.52</u>	\$ <u>3,894</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>324.52</u>	\$ <u>3,894</u>	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.

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/06 Ending: 06/30/07
 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)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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		234		234
8	CNA Competency Tests				
9	TOTALS	\$	\$ 755	\$	\$ 755
10	SUM OF line 9, col. 1 and 2 (e)	\$	755		

- (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	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 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff			Outside Practitioner (other than consultant)						
			Units of Service	Cost		Units	Cost					
1	Licensed Occupational Therapist	N/A	hrs	\$		\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts									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.

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 <u>196,349</u>)		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	\$ (257,761)	1
2	Restatements (describe):		2
3	Beginning Balance, Other Operating Units	5,076,539	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)	19,328	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	(69,776)	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 **Hammond House**# **0030619**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	\$ 664,298	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 664,298	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	112,138	10	
11	CNA Training Reimbursements	3,048	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)	\$ 115,186	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)	\$ 779,993	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	137,781	31	
32	Health Care	242,596	32	
33	General Administration	276,885	33	
B. Capital Expense				
34	Ownership	63,927	34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee	39,476	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 760,665	40	
41	Income before Income Taxes (line 30 minus line 40)**	19,328	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 19,328	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 **Hammond House**

0030619

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	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	520	15,214	26.14	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	365	15,134	36.38	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	430	5,014	10.58	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	1,453	20,753	12.65	17
18	Housekeepers	1,824	24,394	11.73	18
19	Laundry				19
20	Administrator	322	15,909	44.94	20
21	Assistant Administrator	1,824	45,917	22.08	21
22	Other Administrative	255	7,437	25.56	22
23	Office Manager				23
24	Clerical	563	9,340	14.73	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	724	13,565	16.73	29
30	Habilitation Aides (DD Homes)	13,423	163,816	10.83	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	21,703	24,495	\$ 336,493 *	\$ 13.74 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	\$ 3,064	Ln.1,Col.3	35
36	Medical Director	2,400	Ln.9,Col.3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,015	Ln.10,Col.3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	2,304	Ln.10a,Col.3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psychologist</u>	14,375	Ln.10a,Col.3	46
47	<u>Psychiatrist</u>	4,800	Ln.10a,Col.3	47
48	<u>Dental</u>	2,900	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	\$ 30,858		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

0030619

Report Period Beginning: 07/01/06

Ending: 06/30/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Albert Cueller III	Div. Director		\$ 15,909	Workers' Compensation Insurance	\$ 2,015	IDPH License Fee	\$ 308	
Angela Moore	Center Director		45,917	Unemployment Compensation Insurance	5,065	Advertising: Employee Recruitment	308	
Paulette Stallworth	Staff Trng. Coord.		7,437	FICA Taxes	25,098	Health Care Worker Background Check (Indicate # of checks performed _____)		
Gwendolyn Ellis	Service Coord.		7,483	Employee Health Insurance	18,663	Patient Background Checks		
Pamela Halliburton	Service Coord.		6,082	Employee Meals		Staff Literature & Library	271	
				Illinois Municipal Retirement Fund (IMRF)*		Membership Dues	1,925	
				Retirement Income Plan	29,717	Permits & Licenses	656	
				Retirement Plan Fees	948	Professional Fees	89	
				Life Insurance	3,608			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 82,828	Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Central Office - Management & General			\$ 63,468					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 63,468		\$ 85,114		\$ 3,249	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Washington, Pittman & McKeever	Auditors		\$ 1,540	N/A			Out-of-State Travel	\$ 1,277
Digicom, Inc.	Comm. Cons.		259					
Verify	Computers		219					
Others			1,209					
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,227	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 1,277

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hammond House# 0030619Report 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 action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 150 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. \$ 39,476
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? 28%
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 service 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**

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/26/06	167,089	PMTRX00003264	Purchases	ALARM DETECTION SYSTEMS, INC.	\$ 281.10
07/31/06	168,891	PMTRX00003309	Purchases	CUELLER, ALBERT III	17.51
09/08/06	171,475	PMTRX00003365	Purchases	ALARM DETECTION SYSTEMS, INC.	21.73
09/08/06	171,477	PMTRX00003365	Purchases	ALARM DETECTION SYSTEMS, INC.	281.10
11/10/06	178,032	PMTRX00003507	Purchases	ALARM DETECTION SYSTEMS, INC.	281.10
11/20/06	179,244	PMTRX00003527	Purchases	ALARM DETECTION SYSTEMS, INC.	21.73
02/27/07	189,403	PMTRX00003728	Purchases	ALARM DETECTION SYSTEMS, INC.	23.18
03/23/07	192,550	PMTRX00003794	Purchases	ALARM DETECTION SYSTEMS, INC.	154.14
05/21/07	199,693	PMTRX00003941	Purchases	ALARM DETECTION SYSTEMS, INC.	23.18
05/31/07	201,920	PMTRX00004000	Purchases	HOUSTON & ASSOCIATES PROTECTIVE	136.00
					\$ 1,240.77

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION
 FISCAL YEAR 2007 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Distribution Reference	Vendor	Amount
07/31/06	168,891	PMTRX00003309	Purchases	Cueller, Albert, III	\$ 2.49
10/29/06	69,661	GLTRX00016328		Variable allocation	1.91
10/29/06	69,661	GLTRX00016328		Variable allocation	0.22
10/29/06	69,661	GLTRX00016328		Variable allocation	0.36
10/30/06	176,694	PMTRX00003479	Purchases	Lydia Sides - Petty Cash	33.35
10/31/06	177,164	PMTRX00003494	Purchases	Cueller, Albert, III	4.41
10/31/06	179,055	GLTRX00016326	Purchases	American Express	10.67
10/31/06	179,055	GLTRX00016326	Purchases	American Express	1.25
10/31/06	179,055	GLTRX00016326	Purchases	American Express	2.32
10/31/06	179,058	GLTRX00016326	Purchases	American Express	2.15
11/29/06	69,661	GLTRX00016661		Variable allocation	1.82
11/29/06	69,661	GLTRX00016661		Variable allocation	0.13
11/29/06	69,661	GLTRX00016661		Variable allocation	0.22
11/29/06	182,639	GLTRX00016672		Variable allocation	(1.80)
11/29/06	182,639	GLTRX00016672		Variable allocation	(0.13)
11/29/06	182,639	GLTRX00016672		Variable allocation	(0.22)
12/18/06	182,760	PMTRX00003596	Purchases	Cueller, Albert, III	8.16
12/27/06	183,179	PMTRX00003610	Purchases	Lydia Sides - Petty Cash	19.57
12/29/06	69,661	GLTRX00016966		Variable allocation	570.27
12/29/06	69,661	GLTRX00016966		Variable allocation	52.07
12/29/06	69,661	GLTRX00016966		Variable allocation	77.23
01/18/07	185,576	PMTRX00003653	Purchases	Cueller, Albert, III	3.38
01/26/07	186,530	PMTRX00003668	Purchases	Home Depot Credit Services	3.91
01/29/07	69,661	GLTRX00017215		Variable allocation	(20.43)
01/29/07	69,661	GLTRX00017215		Variable allocation	(1.67)
01/29/07	69,661	GLTRX00017215		Variable allocation	(2.64)
01/31/07	188,627	PMTRX00003707	Purchases	Purchase Advantage Card	27.53
02/28/07	69,661	GLTRX00017604		Variable allocation	0.86
02/28/07	69,661	GLTRX00017604		Variable allocation	0.08
02/28/07	69,661	GLTRX00017604		Variable allocation	0.09
02/28/07	190,242	PMTRX00003740	Purchases	Linda Darling	1.40
02/28/07	190,565	PMTRX00003749	Purchases	Cueller, Albert, III	5.39
02/28/07	191,795	PMTRX00003773	Purchases	Purchase Advantage Card	15.18
03/31/07	193,293	PMTRX00003813	Purchases	Cueller, Albert, III	1.28
04/30/07	199,069	PMTRX00003924	Purchases	Purchase Advantage Card	66.18
04/30/07	199,191	PMTRX00003928	Purchases	Cueller, Albert, III	0.28
04/30/07	199,191	PMTRX00003928	Purchases	Cueller, Albert, III	0.20
06/21/07	203,193	PMTRX00004027	Purchases	Cueller, Albert, III	0.88
06/21/07	203,193	PMTRX00004027	Purchases	Cueller, Albert, III	0.62
06/30/07	206,101	PMTRX00004080	Purchases	Lydia Sides - Petty Cash	27.71
06/30/07	206,323	GLTRX00019278	Purchases	American Express	1.89
06/30/07	206,323	GLTRX00019278	Purchases	American Express	7.52
06/30/07	206,323	GLTRX00019278	Purchases	American Express	2.53
06/30/07	206,675	GLTRX00019237	Purchases	American Express	11.38
06/30/07	206,675	GLTRX00019237	Purchases	American Express	1.87
06/30/07	206,705	GLTRX00019239	Purchases	American Express	53.60
06/30/07	206,705	GLTRX00019239	Purchases	American Express	2.51
06/30/07	206,710	GLTRX00019234	Purchases	American Express	5.29
06/30/07	206,710	GLTRX00019234	Purchases	American Express	3.81
06/30/07	207,038	GLTRX00019297	Purchases	American Express	6.41
06/30/07	207,038	GLTRX00019297	Purchases	American Express	8.33
06/30/07	207,038	GLTRX00019297	Purchases	American Express	2.84
06/30/07	207,038	GLTRX00019297	Purchases	American Express	6.86
06/30/07	207,038	GLTRX00019297	Purchases	American Express	7.13
06/30/07	209,816	GLTRX00019689	Purchases	Jewel	27.45
					\$ 1,066.10

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

HAMMOND 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	178.626	81674	Corporate Training Center	Food Service Sanitation Course	Orland Park, IL	April Tyler	Chief Cook/Housekeeper	December 4 & 11, 2006	Ada S. McKinley	150.00
10/31/06	179.055	79834	AmEx	Education Conference	Springfield, IL	Albert Cueller III	Division Director	July 24-25, 2006	Ada S. McKinley	69.04
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	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	102.09
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	154.47
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	86787	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
06/07/07	200.974	87823	ANGELA MOORE	Medical Conference	Elgin, IL	Angela Moore	Center Director	May 24, 2007	Dept. of Public Health	5.90
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 HAMMOND HOUSE							\$ 1,277.52

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

HAMMOND HOUSE

DESCRIPTION	AMOUNT
Mileage and auto rental	\$ 3,795
Gasoline and vehicle repairs	1,601
Automobile insurance	841
	\$ 6,237

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

HAMMOND HOUSE

DESCRIPTION	AMOUNT
Other Staff Expenses	\$ 219
Client Benefits - Accident Insurance	108
Clothing & personal needs	967
Miscellaneous	1
	\$ 1,295