

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0030619</u></p> <p>Facility Name: <u>Hammond House</u></p> <p>Address: <u>6701 South Morgan</u> <u>Chicago</u> <u>60621</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 994-0833</u> Fax # <u>(773) 994-8716</u></p> <p>HFS ID Number: <u>36-2144820-002</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Adrienne Golembiewski</u> Telephone Number: <u>(312) 385-2000</u> Email Address: <u>agolembiewski@adasmckinley.org</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/07</u> to <u>06/30/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:30%; vertical-align: top;"> <p>Officer or Administrator of Provider</p> <p>(Signed) _____</p> <p>(Type or Print Name) <u>HANS J. SCHUSTER</u></p> <p>(Title) <u>Chief Financial Officer</u></p> </td> <td style="width:70%; vertical-align: top;"> <p>(Date) _____</p> </td> </tr> <tr> <td style="width:30%; vertical-align: top;"> <p>Paid Preparer</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (____) _____ Fax # (____) _____</p> </td> <td style="width:70%; vertical-align: top;"> <p>(Date) _____</p> </td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<p>Officer or Administrator of Provider</p> <p>(Signed) _____</p> <p>(Type or Print Name) <u>HANS J. SCHUSTER</u></p> <p>(Title) <u>Chief Financial Officer</u></p>	<p>(Date) _____</p>	<p>Paid Preparer</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (____) _____ Fax # (____) _____</p>	<p>(Date) _____</p>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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<p>Paid Preparer</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (____) _____ Fax # (____) _____</p>	<p>(Date) _____</p>																												

STATE OF ILLINOIS

Facility Name & ID Number Hammond House

0030619 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 5 Patient Days by Level of Care and Primary Source of Payment			
		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	5,414			5,414
14	TOTALS	5,414			5,414

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.89%

D. How many bed-hold days during this year were paid by the Department? 57 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 08/17/86

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/86 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 06/30/08

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

Facility Name & ID Number **Hammond House** # **0030619** Report Period Beginning: **07/01/07** Ending: **06/30/08**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 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	22,294	3,549	3,381	29,224		29,224		29,224		1
2	Food Purchase		39,902		39,902		39,902		39,902		2
3	Housekeeping	23,405	439		23,844		23,844		23,844		3
4	Laundry		781		781		781		781		4
5	Heat and Other Utilities			15,035	15,035		15,035		15,035		5
6	Maintenance	19,056	4,585	22,142	45,783		45,783		45,783		6
7	Other (specify):*			989	989		989		989		7
8	TOTAL General Services	64,755	49,256	41,547	155,558		155,558		155,558		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	155,072	9,893	2,297	167,262		167,262	(1,397)	165,865		10
10a	Therapy			18,213	18,213		18,213		18,213		10a
11	Activities		186	5,397	5,583		5,583		5,583		11
12	Social Services	5,011			5,011		5,011		5,011		12
13	CNA Training		482	2,011	2,493		2,493		2,493		13
14	Program Transportation			2,276	2,276		2,276		2,276		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	160,083	10,561	32,594	203,238		203,238	(1,397)	201,841		16
	C. General Administration										
17	Administrative	80,070		65,319	145,389		145,389		145,389		17
18	Directors Fees										18
19	Professional Services			7,988	7,988		7,988		7,988		19
20	Dues, Fees, Subscriptions & Promotions			3,458	3,458		3,458		3,458		20
21	Clerical & General Office Expenses	9,972	4,745	9,882	24,599		24,599		24,599		21
22	Employee Benefits & Payroll Taxes			79,261	79,261		79,261		79,261		22
23	Inservice Training & Education			1,115	1,115		1,115		1,115		23
24	Travel and Seminar			2,327	2,327		2,327	(1,221)	1,106		24
25	Other Admin. Staff Transportation			6,117	6,117		6,117		6,117		25
26	Insurance-Prop.Liab.Malpractice			4,833	4,833		4,833		4,833		26
27	Other (specify):*			15,448	15,448		15,448	(2,497)	12,951		27
28	TOTAL General Administration	90,042	4,745	195,748	290,535		290,535	(3,718)	286,817		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	314,880	64,562	269,889	649,331		649,331	(5,115)	644,216		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			22,240	22,240	22,240	(2,244)	19,996			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			25,114	25,114	25,114		25,114			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			12,789	12,789	12,789		12,789			34
35	Rent-Equipment & Vehicles			8,556	8,556	8,556		8,556			35
36	Other (specify):*										36
37	TOTAL Ownership			68,699	68,699	68,699	(2,244)	66,455			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			37,558	37,558	37,558		37,558			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			37,558	37,558	37,558		37,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	314,880	64,562	376,146	755,588	755,588	(7,359)	748,229			45

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

STATE OF ILLINOIS

Facility Name & ID Number **Hammond House**

0030619

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

Ending: **06/30/08**

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)	(2,497)	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)	\$ (4,741)		\$	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))	\$ (4,741)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)		\$		47

STATE OF ILLINOIS

Hammond House

ID# 0030619

Report Period Beginning: 07/01/07

Ending: 06/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12	Medical & Dental Service Payments	(1,397)	10	12
13	Out-of-Town Travel	(1,221)	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	(2,618)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hammond House

0030619

Report Period Beginning:

07/01/07

Ending:

06/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,397)	0	0	0	0	0	0	0	0	0	0	(1,397)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,397)	0	0	0	0	0	0	0	0	0	0	(1,397)	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	(1,221)	0	0	0	0	0	0	0	0	0	0	(1,221)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,497)	0	0	0	0	0	0	0	0	0	0	(2,497)	27
28	TOTAL General Administration	(3,718)	0	0	0	0	0	0	0	0	0	0	(3,718)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,115)	0	0	0	0	0	0	0	0	0	0	(5,115)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/07 Ending: 06/30/08

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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(7,359)	0	0	0	0	0	0	0	0	0	0	(7,359) 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
		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: 07/01/07 Ending: 06/30/08

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: 07/01/07 Ending: 06/30/08

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	98	\$ 3,479,235	\$ 1,801,235	668,028	\$ 63,984	1
2	Ln. 17	Central Administration Exp.	Direct Cost	98	72,599		668,028	1,335	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				\$ 3,551,834	\$ 1,801,235		\$ 65,319	25

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	\$ 267,781	12/1/2027	0.0925	\$ 25,114	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	\$ 267,781			\$ 25,114	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	\$ 267,781			\$ 25,114	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 Hammond House

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 2007 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 2008 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>2003</td><td>8</td></tr> <tr><td>2004</td><td>9</td></tr> <tr><td>2005</td><td>10</td></tr> <tr><td>2006</td><td>11</td></tr> <tr><td>2007</td><td>12</td></tr> </table>	2003	8	2004	9	2005	10	2006	11	2007	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 2007 \$</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 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	8																										
2004	9																										
2005	10																										
2006	11																										
2007	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 2007 on the lines provided below. Enter only the portion of total 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 2007.

	(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 directly 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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:

07/01/07 Ending:

06/30/08

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>\$ 19,952</u>	1
2					2
3	TOTALS			\$ 19,952	3

STATE OF ILLINOIS

Facility Name & ID Number Hammond House

0030619

Report Period Beginning:

07/01/07

Ending:

06/30/08

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)	\$ 279,928	4
5				1988	8,618	344	25	287	(57)	7,181	5
6				1999	13,000	1,300	10	1,300		12,350	6
7				2002	10,460	1,046	10	1,046		6,450	7
8				2004	2,165	433	5	433		2,003	8
			Improvement Type**								
9		Interior repainting, kitchen, dining room, washroom									9
10		laundry room, and bathroom repair		2004	13,600	1,360	10	1,360		5,950	10
11		Upflow Bryant furnace		2005	2,495	499	5	499		1,850	11
12		Goodman 5-ton furnace		2005	2,550	510	5	510		1,934	12
13		Bathroom renovations		2008	21,151	1,674	10	1,674		1,674	13
14		Bathroom renovations - additional		2008	1,994	42	10	42		42	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

STATE OF ILLINOIS

Facility Name & ID Number Hammond House

0030619

Report Period Beginning:

07/01/07

Ending:

06/30/08

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)		\$ 404,073	\$ 20,330		\$ 18,086	\$ (2,244)	\$ 319,362	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,411	\$ 1,061	\$ 1,061		5 Years	\$ 3,097	71
72	Current Year Purchases	4,224	809	809		5 Years	819	72
73	Fully Depreciated Assets	39,471	40	40		5 Years	39,472	73
74								74
75	TOTALS	\$ 49,106	\$ 1,910	\$ 1,910			\$ 43,388	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)	\$ 473,131	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,240	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,996	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)	\$ 362,750	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.

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/07 Ending: 06/30/08

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:				\$ 12,789			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 12,789			7

10. Effective dates of current rental agreement:
 Beginning 07/01/07
 Ending 06/30/08

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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: \$ 4,787 Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Staff transportation</u>	<u>2006 Toyota Sienna</u>	\$ <u>314.10</u>	\$ <u>3,769</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 314.10	\$ 3,769	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>120</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>15</u></p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	ALLOCATION OF COSTS (d)			
	1	2	3	4
	Facility		Contract	Total
Drop-outs	Completed			
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		482		482
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments		2,011		2,011
8 CNA Competency Tests				
9 TOTALS	\$	\$ 2,493	\$	\$ 2,493
10 SUM OF line 9, col. 1 and 2 (e)	\$	2,493		

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (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.

Facility Name & ID Number **Hammond House**

0030619 Report Period Beginning:

07/01/07

Ending:

06/30/08

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **Hammond House**

0030619

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

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/08**
(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	\$	\$ 3,101,636	1
2	Cash-Patient Deposits		128,487	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 245,804)		4,470,691	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		100,265	6
7	Other Prepaid Expenses		90,652	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 7,891,731	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		402,080	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,506,609	14
15	Leasehold Improvements, at Historical Cost		1,962,591	15
16	Equipment, at Historical Cost		4,441,038	16
17	Accumulated Depreciation (book methods)		(10,104,756)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		387,789	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		96,765	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 5,647,615	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 13,539,346	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 3,450,880	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		132,257	28
29	Short-Term Notes Payable		7,341	29
30	Accrued Salaries Payable		1,691,127	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,776	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		94,016	35
36	Other Current Liabilities(specify):			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 5,391,397	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		12,460	39
40	Mortgage Payable		1,830,637	40
41	Bonds Payable		1,340,000	41
42	Deferred Compensation		31,407	42
43	Other Long-Term Liabilities(specify):			43
44	<u>Pension Benefit Liability</u>		3,232,691	43
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,447,195	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 11,838,592	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,700,754	\$ 1,700,754	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,700,754	\$ 13,539,346	48

*(See instructions.)

Facility Name & ID Number Hammond House

0030619

Report Period Beginning: 07/01/07

Ending: 06/30/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (238,433)	1
2	Restatements (describe):		2
3	Beginning Balance - Other Operating Units	5,144,940	3
4	Prior Year's Adjustments	(3,246,494)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,660,013	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	24,516	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	16,225	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Operating Income-Other Operating Units		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 40,741	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)	\$ 1,700,754	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Hammond House

0030619

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	\$ 669,056	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 669,056	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	107,929	10
11	CNA Training Reimbursements	2,257	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)	\$ 110,186	23
D. Non-Operating Revenue			
24	Contributions	20	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		842	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 842	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 780,104	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	155,558	31
32	Health Care	203,238	32
33	General Administration	290,535	33
B. Capital Expense			
34	Ownership	68,699	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	37,558	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 755,588	40
41	Income before Income Taxes (line 30 minus line 40)**	24,516	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 24,516	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: **07/01/07**

Ending: **06/30/08**

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	371	11,570	27.42	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	128	5,011	34.32	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,824	19,922	9.58	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	1,094	19,056	15.27	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	365	13,932	33.49	20
21	Assistant Administrator	1,824	43,788	21.05	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	621	9,697	13.97	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator	1,107	22,349	17.91	29
30	Habilitation Aides (DD Homes)	14,315	169,555	10.52	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	21,649	314,880 *	12.88	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	74	3,381	Ln.1,Col.3	35
36	Medical Director	24	2,400	Ln.9,Col.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	900	Ln.10,Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	62	2,793	Ln.10a,Col.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	158	10,260	Ln.10a,Col.3	46
47	<u>Psychiatrist</u>	52	5,160	Ln.10a,Col.3	47
48	<u>Dental</u>	37	1,397	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	417	26,291		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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5									6	7	8	9	10	11	12	13
				Amount of Expense Amortized Per Year																
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013								
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name & ID Number Hammond House

0030619

Report Period Beginning: 07/01/07

Ending: 06/30/08

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. \$ 1,350 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. \$ 37,558
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 27%
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 yet finished
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - COLUMN 3, LINE 7 - OTHERS - GENERAL SERVICES
FISCAL YEAR 2008 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/31/07	207,862	PMTRX00004137	SECURITY SERVICES	HOUSTON & ASSOCIATES PROTECTIVE	105.60
07/31/07	209,086	PMTRX00004171	SECURITY SERVICES	HOUSTON & ASSOCIATES PROTECTIVE	123.20
08/13/07	209,408	PMTRX00004179	SECURITY SERVICES	HOUSTON & ASSOCIATES PROTECTIVE	123.20
08/22/07	209,953	PMTRX00004206	ACCT. #58999	ALARM DETECTION SYSTEMS, INC.	23.18
08/29/07	210,524	PMTRX00004225	SECURITY SERVICES	HOUSTON & ASSOCIATES PROTECTIVE	123.20
08/29/07	210,667	PMTRX00004229	SECURITY SERVICES	HOUSTON & ASSOCIATES PROTECTIVE	70.40
01/03/08	224,630	PMTRX00004591	ACCT #58999	ALARM DETECTION SYSTEMS, INC.	31.07
05/01/08	240,629	GLTRX00023661	Corr. Ck.92833-Lux Security Sy	LUX SECURITY SYSTEM	35.38
05/01/08	240,630	GLTRX00023661	Corr. Ck.95181-Lux Security Sy	LUX SECURITY SYSTEM	354.00
					\$ 989.23

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION
 FISCAL YEAR 2008 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Ref.	Vendor	Amount
07/25/07	207.213	PMTRX00004113	E.E.A. F/07/07	ALBERT CUELLER III	4.04
07/31/07	213.023	GLTRX00020172	EXP CK#89821- AMEX 07/07	AMEX	6.25
07/31/07	213.023	GLTRX00020172	EXP CK#89821- AMEX 07/07	AMEX	4.08
07/31/07	213.023	GLTRX00020172	EXP CK#89821- AMEX 07/07	AMEX	4.44
08/31/07	211.556	PMTRX00004243	E.E.A. F/08/07	ALBERT CUELLER III	3.19
08/31/07	211.953	PMTRX00004257	PTY. CSH. F/08/07	LYDIA M. SIDES-PETTY CASH	19.48
08/31/07	212.411	PMTRX00004274	ACCT. #6030 3751 0002 9070	PURCHASE ADVANTAGE CARD	73.81
09/30/07	216.159	PMTRX00004360	ACCT. #6030 3751 0002 9070	PURCHASE ADVANTAGE CARD	7.23
10/29/07	69.661	GLTRX00020863	Variable Allocation - 10/07	Variable Allocation	0.24
10/31/07	218.475	PMTRX00004413	E.E.A. F/09/07	ALBERT CUELLER III	0.96
10/31/07	218.915	PMTRX00004427	E.E.A F/10/07	ALBERT CUELLER III	1.56
10/31/07	219.009	PMTRX00004437	CATERING	BIAGO'S CATERING, BANQUETS AND EVENTS	7.13
10/31/07	219.012	PMTRX00004437	CATERING	BIAGO'S CATERING, BANQUETS AND EVENTS	9.71
10/31/07	219.221	PMTRX00004432	ACCT. #6030 3751 0002 9070	PURCHASE ADVANTAGE CARD	27.32
10/31/07	220.121	GLTRX00020914	EXP Check #90306 - AMEX 08/07	AMEX	22.89
11/29/07	69.661	GLTRX00021275	Variable Allocation - 11/07	Variable Allocation	1.53
11/30/07	222.384	PMTRX00004508	E.E.A.F./11/07	ALBERT CUELLER III	1.24
12/11/07	222.521	PMTRX00004514	OFFICE SUPPLIES	LYDIA M. SIDES	79.93
12/29/07	69.661	GLTRX00021635	Variable Allocation - 12/07	Variable Allocation	55.52
01/15/08	226.465	PMTRX00004629	E.E.A. F/12/07	ALBERT CUELLER III	8.58
01/24/08	227.213	PMTRX00004653	PTY.CSH. F/01/08	LYDIA M. SIDES-PETTY CASH	10.08
01/24/08	227.283	PMTRX00004653	LUNCH FOR IN-SERVICE	PAULETTE STALLWORTH	22.13
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	0.22
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	(1.67)
02/29/08	231.245	PMTRX00004771	PTY. CSH. F/02/08	LYDIA M. SIDES-PETTY CASH	20.52
03/31/08	234.607	GLTRX00022894	EXP CK#92922--ADD'L AMEX 11/07	AMEX	5.20
03/31/08	234.607	GLTRX00022894	EXP CK#92922--ADD'L AMEX 11/07	AMEX	2.64
04/30/08	239.799	GLTRX00023384	EXP CK#93756- ADD'L AMEX 12/07	AMEX	3.25
04/30/08	239.799	GLTRX00023384	EXP CK#93756- ADD'L AMEX 12/07	AMEX	2.83
04/30/08	239.800	GLTRX00023385	EXP CK#94671-ADD'L AMEX 01/08	AMEX	1.89
04/30/08	239.803	GLTRX00023387	EXP CK#95357-ADD'L AMEX 02/08	AMEX	2.63
04/30/08	239.803	GLTRX00023387	EXP CK#95357-ADD'L AMEX 02/08	AMEX	2.83
04/30/08	239.803	GLTRX00023387	EXP CK#95357-ADD'L AMEX 02/08	AMEX	7.00
06/30/08	244.376	PMTRX00005113	E.E.A. F/06/08	ALBERT CUELLER III	4.68
06/30/08	246.692	GLTRX00024260	Rec Add'l AMEX-03/08	AMEX	2.55
06/30/08	246.693	GLTRX00024261	Rec Add'l AMEX-04/08	AMEX	3.03
06/30/08	246.693	GLTRX00024261	Rec Add'l AMEX-04/08	AMEX	3.22
06/30/08	246.694	GLTRX00024264	EXP CK#108645 - AMEX 05/08	AMEX	3.67
06/30/08	246.694	GLTRX00024264	EXP CK#108645 - AMEX 05/08	AMEX	4.94
06/30/08	246.694	GLTRX00024264	EXP CK#108645 - AMEX 05/08	AMEX	4.64
06/30/08	249.314	GLTRX00024562	EXP CK#109529 - AMEX 06/08	AMEX	3.38
06/30/08	249.314	GLTRX00024562	EXP CK#109529 - AMEX 06/08	AMEX	5.18
06/30/08	249.314	GLTRX00024562	EXP CK#109529 - AMEX 06/08	AMEX	12.90
10/29/07	69.661	GLTRX00020863	Variable Allocation - 10/07	Variable Allocation	2.34
11/29/07	69.661	GLTRX00021275	Variable Allocation - 11/07	Variable Allocation	17.84
12/29/07	69.661	GLTRX00021635	Variable Allocation - 12/07	Variable Allocation	582.94
01/08/08	225.061	PMTRX00004600	PTY. CSH. F/01/08	ANGELA MOORE-PETTY CASH	6.50
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	2.52
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	(18.79)
07/25/07	207.213	PMTRX00004113	E.E.A. F/07/07	ALBERT CUELLER III	2.83
08/31/07	211.556	PMTRX00004243	E.E.A. F/08/07	ALBERT CUELLER III	2.23
10/29/07	69.661	GLTRX00020863	Variable Allocation - 10/07	Variable Allocation	0.19
10/31/07	218.915	PMTRX00004427	E.E.A F/10/07	ALBERT CUELLER III	0.89
11/29/07	69.661	GLTRX00021275	Variable Allocation - 11/07	Variable Allocation	1.26
11/30/07	222.384	PMTRX00004508	E.E.A.F./11/07	ALBERT CUELLER III	0.71
12/29/07	69.661	GLTRX00021635	Variable Allocation - 12/07	Variable Allocation	44.06
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	0.18
01/29/08	69.661	GLTRX00022023	Variable Allocation - 01/08	Variable Allocation	(1.31)
03/31/08	234.607	GLTRX00022894	EXP CK#92922--ADD'L AMEX 11/07	AMEX	1.51
06/30/08	244.376	PMTRX00005113	E.E.A. F/06/08	ALBERT CUELLER III	2.66
				#####	

Hammond House-2008-0030619.xls

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE XIX-G (Page 21) - ANALYSIS OF IN-STATE TRAVEL AND SEMINAR - Account 3310
 FOR THE FISCAL YEAR ENDED JUNE 30, 2008

HAMMOND HOUSE

DATE	CHECK NO.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	ACCOUNT 3310				Account 3330 Amount	In-State Travel & Seminar	
										15177081 Amount	15178881 Amount	15000031 Amount	Total			
07/25/07	207,213	89274	ALBERT CUELLER III	Lunch with staff	Oak Lawn, IL	Albert Cueller III	Division Director	July 17, 2007					0.96	1.37	2.33	2.33
07/31/07	213,023	89821	AmEx 07/07	Business lunch	Chicago, IL	Albert Cueller III	Division Director	June 28, 2007	Ada S. McKinley						-	8.39
07/31/07	213,023	89821	AmEx 07/07	Lunch with staff	Chicago, IL	Albert Cueller III	Division Director	July 18, 2007	Ada S. McKinley						-	6.06
07/31/07	213,023	89821	AmEx 07/07	Business lunch	Chicago, IL	Albert Cueller III	Division Director	July 24, 2007	Ada S. McKinley						-	49.93
08/31/07	212,491	90705	I.C.A.N., INC.	I.C.A.N. Annual conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 26, 2007	I.C.A.N., INC.			63.80	63.80			63.80
09/27/07	213,411	90822	CLAUDA BOOSE	Lunch for CPR First-Aid & Medication Class	Chicago, IL	Clauda Boose	Health Services Coordinator	September 7, 2007	Ada S. McKinley							17.85
09/25/07	213,706	90923	CROWN PLAZA	I.C.A.N. Annual conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 28, 2007	I.C.A.N., INC.			282.48	282.48			282.48
09/26/07	213,724	90924	LINDA DARLING	Business lunch	Chicago, IL	Linda Darling	Dir. Of Habilitation Services	September 14, 2007	Ada S. McKinley							45.69
09/27/07	214,110	90990	ALBERT CUELLER III	Lunch	Chicago, IL	Albert Cueller III	Division Director	Sept. 12, 2007	Ada S. McKinley			8.12	11.60	19.72		19.72
10/31/07	220,374	91158	AmEx 09/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 25 - 27, 2007	IARF			2.17	3.80	5.97		5.97
10/31/07	220,374	91158	AmEx 09/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 25 - 27, 2007	IARF			0.77	1.35	2.12		2.12
10/31/07	220,374	91158	AmEx 09/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 25 - 27, 2007	IARF			0.67	1.17	1.84		1.84
10/31/07	220,374	91158	AmEx 09/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 25 - 27, 2007	IARF			4.99	8.75	13.74		13.74
10/31/07	220,374	91158	AmEx 09/07	Lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	August 31, 2007	Ada S. McKinley							17.69
10/31/07	220,374	91158	AmEx 09/07	Business lunch	Chicago, IL	Albert Cueller III	Division Director	Sept. 7, 2007	Ada S. McKinley							1.99
09/30/07	215,421	91263	JOCELYN NICHOLS - PETTY CASH	Sanitation Class	Chicago, IL	Jocelyn Nichols	Center Director	September 13, 2007	Ada S. McKinley							5.56
12/31/07	226,429	91979	AmEx 10/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Sept. 25 - 27, 2007	IARF			1.60	2.80	4.40		4.40
12/31/07	226,429	91979	AmEx 10/07	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	Oct. 24, 2007	IARF			4.33	7.59	11.92		11.92
12/31/07	226,429	91979	AmEx 10/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	October 9, 2007	Ada S. McKinley							2.06
12/31/07	226,429	91979	AmEx 10/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	October 11, 2007	Ada S. McKinley							3.40
12/31/07	226,429	91979	AmEx 10/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	October 24, 2007	Ada S. McKinley							16.79
10/31/07	218,882	92072	CLAUDA BOOSE	Fardive Dyskenia Seminar	Chicago, IL	Clauda Boose	Health Services Coordinator	November 1, 2007	Ada S. McKinley							1.78
10/31/07	218,915	92085	ALBERT CUELLER III	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	October 24, 2007	IARF							1.68
03/31/08	234,607	92922	AmEx 11/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	November 12, 2007	Ada S. McKinley							5.84
03/31/08	234,607	92922	AmEx 11/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	November 13, 2007	Ada S. McKinley							14.65
03/31/08	234,607	92922	AmEx 11/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	November 26, 2007	Ada S. McKinley							3.47
04/30/08	239,799	93756	AmEx 12/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Nov. 28 - 29, 2007	IARF			4.37	7.67	12.04		12.04
04/30/08	239,799	93756	AmEx 12/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Nov. 28 - 29, 2007	IARF			9.03	15.84	24.87		24.87
04/30/08	239,799	93756	AmEx 12/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Nov. 28 - 29, 2007	IARF			1.95	3.42	5.37		5.37
04/30/08	239,799	93756	AmEx 12/07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	Dec. 13, 2007	IARF			2.00	3.51	5.51		5.51
04/30/08	239,799	93756	AmEx 12/07	Business meal	Chicago, IL	Albert Cueller III	Division Director	December 17, 2007	Ada S. McKinley							1.74
01/10/08	225,883	93821	ARC OF ILLINOIS	OMRP Leadership Seminar	Alsip, IL	Angela Moore	Center Director	January 22, 2008	ARC OF ILLINOIS	108.00				108.00		108.00
01/31/08	228,092	94622	ALBERT CUELLER III	Lunch with HUD consultant	Chicago, IL	Albert Cueller III	Division Director	January 8, 2008	Ada S. McKinley			16.20	16.20			16.20
04/30/08	239,800	94671	AmEx 01/08	HUD training	Chicago, IL	Albert Cueller III	Division Director	January 14, 2008	HUD							4.39
04/30/08	239,800	94671	AmEx 01/08	Education Conference	Springfield, IL	Albert Cueller III	Division Director	January 23 - 24, 2008	IARF			0.39	0.66	1.04		1.04
04/30/08	239,800	94671	AmEx 01/08	Education Conference	Springfield, IL	Albert Cueller III	Division Director	January 23 - 24, 2008	IARF			0.54	0.96	1.50		1.50
04/30/08	239,800	94671	AmEx 01/08	Education Conference	Springfield, IL	Albert Cueller III	Division Director	January 23 - 24, 2008	IARF			4.33	7.59	11.92		11.92
04/30/08	239,800	94671	AmEx 01/08	Education Conference	Springfield, IL	Albert Cueller III	Division Director	January 23 - 24, 2008	IARF			1.82	3.19	5.01		5.01
04/30/08	239,800	94671	AmEx 01/08	Education Conference	Springfield, IL	Albert Cueller III	Division Director	January 23 - 24, 2008	IARF			1.65	2.90	4.55		4.55
02/29/08	232,402	94671	AmEx 01/08	IARF meeting	Springfield, IL	Albert Cueller III	Division Director	February 23, 2008	IARF							6.09
04/30/08	239,803	95357	Adst. AmEx 02/08	Staff meeting	Chicago, IL	Albert Cueller III	Division Director	February 19, 2008	Ada S. McKinley							21.86
03/20/08	233,384	95684	CROWN PLAZA	2008 HUD Training Conference	Springfield, IL	G. Ellis, P. Halliburton	Service Coordinators	April 30, 2008	Illinois Association of Service Coordinators			76.16	76.16			76.16
03/20/08	233,389	95699	ILLINOIS ASSO. OF SERVICE COORDINATORS	2008 HUD Training Conference	Springfield, IL	G. Ellis, P. Halliburton	Service Coordinators	April 30, 2008	Illinois Association of Service Coordinators			60.00	60.00			60.00
03/31/08	235,640	107201	ALBERT CUELLER III	Business meal	Chicago, IL	Albert Cueller III	Division Director	March 21, 2008	Ada S. McKinley							1.68
04/30/08	238,468	107864	ALBERT CUELLER III	Energy Conference	Springfield, IL	Albert Cueller III	Division Director	April 24, 2008	ARC of Illinois							17.67
06/30/08	244,330	109441	GWIENDOLYN ELLIS	2008 HUD Training Conference	Springfield, IL	G. Ellis, P. Halliburton	Service Coordinator	April 30, 2008	Illinois Association of Service Coordinators			9.25	9.25			9.25
06/30/08	244,334	109440	PAMELA HALLIBURTON	2008 HUD Training Conference	Springfield, IL	P. Halliburton	Service Coordinator	April 30, 2008	Illinois Association of Service Coordinators			7.86	7.86			7.86
06/30/08	244,333	109449	PAMELA HALLIBURTON	2008 HUD Training Conference	Springfield, IL	P. Halliburton	Service Coordinator	April 30, 2008	Illinois Association of Service Coordinators							3.86
06/30/08	249,314	109529	Adst. AmEx 06/08	Business meeting	Chicago, IL	Albert Cueller III	Division Director	June 5, 2008	Ada S. McKinley							2.25
06/30/08	249,314	109529	Adst. AmEx 06/08	Business meeting	Chicago, IL	Albert Cueller III	Division Director	June 18, 2008	Ada S. McKinley							1.28
06/30/08	249,314	109529	Adst. AmEx 06/08	Business meeting	Chicago, IL	Albert Cueller III	Division Director	June 23, 2008	Ada S. McKinley							0.50
07/31/07	213,014		Reconcile June 2007 AmEx	Business meal	Chicago, IL	Albert Cueller III	Division Director	June 2, 2007	Ada S. McKinley							7.19
07/31/07	213,014		JUNE 2007 AmEx	Education Conference	Rockford, IL	Albert Cueller III	Division Director	May 30, 2007	Ada S. McKinley							3.16
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Chicago, IL	Albert Cueller III	Division Director	April 8, 2008	Ada S. McKinley							5.27
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 25, 2008	Ada S. McKinley							2.01
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 25, 2008	Ada S. McKinley							9.69
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 16 - 17, 2008	Ada S. McKinley			2.35	4.12	6.47		6.47
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 16 - 17, 2008	Ada S. McKinley			1.97	3.45	5.42		5.42
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 16 - 17, 2008	Ada S. McKinley			0.71	1.25	1.96		1.96
06/30/08	246,693		Adst. AmEx 04/08	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 16 - 17, 2008	Ada S. McKinley			4.40	7.72	12.12		12.12
06/30/08	247,472		Reconcile AmEx FY07	Business meal	Chicago, IL	Albert Cueller III	Division Director	January 30, 2007	Ada S. McKinley							10.93
06/30/08	247,472		Reconcile AmEx FY07	Business meal	Chicago, IL	Albert Cueller III	Division Director	February 20, 2007	Ada S. McKinley							7.04
06/30/08	247,472		Reconcile AmEx FY07	Business meal	Springfield, IL	Albert Cueller III	Division Director	February 20, 2007	Ada S. McKinley							0.55
06/30/08	247,472		Reconcile AmEx FY07	Education Conference	Springfield, IL	Albert Cueller III	Division Director	February 20, 2007	Ada S. McKinley			1.70	2.97	4.67		4.67
06/30/08	249,314		Adst. AmEx 06/08	Business meeting	Chicago, IL	Albert Cueller III	Division Director	June 18, 2008	Ada S. McKinley							7.11
TOTAL HAMMOND HOUSE										\$ 124.20	\$ 214.08	\$ 453.12	\$ 791.40	\$ 313.94	\$ 1,105.34	

**ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
 FISCAL YEAR 2008 COST REPORT**

DESCRIPTION	HAMMOND HOUSE
Mileage and auto rental	\$ 3,281
Gasoline and vehicle repairs	2,079
Automobile insurance	757
Staff Transportation - Local	-
	\$ 6,117

**ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
 FISCAL YEAR 2008 COST REPORT**

DESCRIPTION	HAMMOND HOUSE
Other Staff Expenses	\$ 367
Parent Meetings	17
Benefits - Workers' Compensation	-
Client Benefits - Accident Insurance	79
Clothing & Personal Needs	2,497
Miscellaneous	12,487
Bank Service Charges	1
Provision for Doubtful Accounts	-
	\$ 15,448