		FOR BHF USE					

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0030619

Facility Name: HAMMOND HOUSE

Address: 6701 South Morgan (Number) Chicago (City) 60621 (Zip Code)

County: Cook

Telephone Number: (773) 994-0833 **Fax #** (773) 994-8716

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Adrienne Golembiewski **Telephone Number:** (312) 385-2000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) HANS J. SCHUSTER
(Title) Chief Financial Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	15	ICF/DD 16 or Less	15	5,475	6
7	15	TOTALS	15	5,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,344			5,344	13
14	TOTALS	5,344			5,344	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.61%

D. How many bed-hold days during this year were paid by the Department?
131 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 07/01/86 NO [ ]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: N/A Fiscal Year: 06/30/10

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	22,956	2,550	3,144	28,650		28,650		28,650			1
2	Food Purchase		35,316		35,316		35,316		35,316			2
3	Housekeeping	17,448	1,233		18,681		18,681		18,681			3
4	Laundry		827		827		827		827			4
5	Heat and Other Utilities			13,559	13,559		13,559		13,559			5
6	Maintenance	14,604	5,543	17,808	37,955		37,955		37,955			6
7	Other (specify):*			2,414	2,414		2,414		2,414			7
8	**TOTAL General Services**	55,008	45,469	36,925	137,402		137,402		137,402			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	169,531	12,425	6,352	188,308		188,308	(2,802)	185,506			10
10a	Therapy			7,677	7,677		7,677		7,677			10a
11	Activities		51	2,761	2,812		2,812		2,812			11
12	Social Services	13,926			13,926		13,926		13,926			12
13	CNA Training		713	490	1,203		1,203		1,203			13
14	Program Transportation			998	998		998		998			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	183,457	13,189	20,478	217,124		217,124	(2,802)	214,322			16
	C. General Administration											
17	Administrative	81,983		64,319	146,302		146,302		146,302			17
18	Directors Fees											18
19	Professional Services			4,091	4,091		4,091		4,091			19
20	Dues, Fees, Subscriptions & Promotions			3,234	3,234		3,234		3,234			20
21	Clerical & General Office Expenses	10,209	6,943	17,781	34,933		34,933		34,933			21
22	Employee Benefits & Payroll Taxes			87,422	87,422		87,422		87,422			22
23	Inservice Training & Education			696	696		696		696			23
24	Travel and Seminar			2,389	2,389		2,389	(803)	1,586			24
25	Other Admin. Staff Transportation			5,607	5,607		5,607		5,607			25
26	Insurance-Prop.Liab.Malpractice			4,227	4,227		4,227		4,227			26
27	Other (specify):*			20,215	20,215		20,215	(3,164)	17,051			27
28	**TOTAL General Administration**	92,192	6,943	209,981	309,116		309,116	(3,967)	305,149			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	330,657	65,601	267,384	663,642		663,642	(6,769)	656,873			29

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

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

Facility Name & ID Number HAMMOND HOUSE #0030619 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,731	21,731		21,731	(2,245)	19,486			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,744	23,744		23,744		23,744			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			7,302	7,302		7,302		7,302			34
35	Rent-Equipment & Vehicles			9,375	9,375		9,375		9,375			35
36	Other (specify):*											36
37	**TOTAL Ownership**			62,152	62,152		62,152	(2,245)	59,907			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			37,144	37,144		37,144		37,144			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			37,144	37,144		37,144		37,144			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	330,657	65,601	366,680	762,938		762,938	(9,014)	753,924			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: 07/01/09 Ending: 06/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(2,245)	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)	(3,164)	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)**	$ (5,409)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,409)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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	(2,802)	10	12
13	Out-of-Town Travel	(803)	24	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,605)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HAMMOND HOUSE **#** 0030619 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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	(2,802)	0	0	0	0	0	0	0	0	0	0	(2,802)	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**	(2,802)	0	0	0	0	0	0	0	0	0	0	(2,802)	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	(803)	0	0	0	0	0	0	0	0	0	0	(803)	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):*	(3,164)	0	0	0	0	0	0	0	0	0	0	(3,164)	27
28	**TOTAL General Administration**	(3,967)	0	0	0	0	0	0	0	0	0	0	(3,967)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,769)	0	0	0	0	0	0	0	0	0	0	(6,769)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HAMMOND HOUSE **#** 0030619 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	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**	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,014)	0	0	0	0	0	0	0	0	0	0	(9,014)	45

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [X] NO

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

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

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 07/01/09 Ending: 06/30/10

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Ln. 17	Central Administration Exp.	Direct Cost	35,566,628	97	$ 3,308,980	$ 1,748,477	676,888	$ 62,975	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,566,628	97	70,630		676,888	1,344	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					$ 3,379,610	$ 1,748,477		$ 64,319	25

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	H.U.D.		X	Mortgage	$2,657.00	12/01/86	$ 334,060	$ 252,223	12/1/2027	0.0925	$ 23,744	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	$ 252,223			$ 23,744	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	$ 252,223			$ 23,744	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** 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 **#** 0030619 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 directly used for nursing home services? YES NO

If YES, attach an explanation and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 07/01/09 Ending: 06/30/10

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15		1986	1986	$ 328,040	$ 13,122	25	$ 10,935	$ (2,187)	$ 308,358	4
5				1988	8,618	345	25	287	(58)	7,929	5
6				1999	13,000		10			13,000	6
7				2002	10,460	1,046	10	1,046		8,542	7
8				2004	2,165		5			2,165	8
	Improvement Type**										
9	Interior repainting, kitchen, dining room, washroom										9
10	laundry room, and bathroom repairs			2004	13,600	1,360	10	1,360		8,670	10
11	Upflow Bryant furnace			2005	2,495	146	5	146		2,495	11
12	Goodman 5-ton furnace			2005	2,550	106	5	106		2,550	12
13	Bathroom renovations			2008	21,151	2,115	10	2,115		5,905	13
14	Bathroom renovations - additional			2008	1,994	199	10	199		440	14
15	Commercial dishwasher			2010	4,921	123	5	123		123	15
16	Commercial dishwasher			2010	4,922	123	5	123		123	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: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 413,916	$ 18,685		$ 16,440	$ (2,245)	$ 360,300	70

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	$ 15,455	$ 3,011	$ 3,011	$	5 Years	$ 8,817	71
72	Current Year Purchases	197	35	35		5 Years	35	72
73	Fully Depreciated Assets	56,880				5 Years	56,880	73
74								74
75	TOTALS	$ 72,532	$ 3,046	$ 3,046	$		$ 65,732	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)	$ 506,400	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,731	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,486	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,245)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 426,032	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: 07/01/09 Ending: 06/30/10

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 [X] 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:				$ 7,302			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 7,302 **			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 . N/A

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/09
Ending 06/30/10

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 4,114 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	Staff transportation	2006 Toyota Sienna	$ 438.45	$ 5,261	17
18					18
19					19
20					20
21	TOTAL		$ 438.45	$ 5,261	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.

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		713		713
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		490		490
8	CNA Competency Tests				
9	TOTALS	$	$ 1,203	$	$ 1,203
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,203			

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

(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.
(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: 07/01/09 Ending: 06/30/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			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	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: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 594,432	1
2	Cash-Patient Deposits		159,898	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 319,848)		9,337,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		166,446	6
7	Other Prepaid Expenses		108,837	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 10,367,244	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		399,606	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,702,680	14
15	Leasehold Improvements, at Historical Cost		2,082,363	15
16	Equipment, at Historical Cost		4,573,645	16
17	Accumulated Depreciation (book methods)		(10,994,797)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		273,138	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Costs, Security Deposits		73,876	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 5,066,010	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 15,433,254	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,529,694	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		165,144	28
29	Short-Term Notes Payable		722,561	29
30	Accrued Salaries Payable		2,639,034	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		25,035	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		164,857	35
	Other Current Liabilities(specify):			
36	Unfunded Pension Liability		172,723	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 6,419,048	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,736,776	40
41	Bonds Payable		1,050,000	41
42	Deferred Compensation		45,615	42
	Other Long-Term Liabilities(specify):			
43	Pension Benefit Liability		6,037,451	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 8,869,842	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 15,288,890	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 144,364	$ 144,364	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 144,364	$ 15,433,254	48

*(See instructions.)

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (151,035)	1
2	Restatements (describe):		2
3	**Beginning Balance - Other Operating Units**	2,722,990	3
4	**Prior Year's Adjustment**	(2,807,420)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (235,465)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,480	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**	369,349	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 379,829	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)**	$ 144,364	24 *

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 659,018	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 659,018	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	99,212	10
11	CNA Training Reimbursements		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)**	$ 99,212	23
	D. Non-Operating Revenue		
24	Contributions	14,000	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,000	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Proceeds, miscellaneous	1,188	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,188	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 773,418	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	137,402	31
32	Health Care	217,124	32
33	General Administration	309,116	33
	B. Capital Expense		
34	Ownership	62,152	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	37,144	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 762,938	40
41	**Income before Income Taxes (line 30 minus line 40)****	10,480	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 10,480	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: 07/01/09 Ending: 06/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	534	601	14,825	24.67	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	391	446	13,926	31.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,824	2,080	22,956	11.04	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	762	866	14,604	16.86	17
18	Housekeepers	1,447	1,650	17,448	10.57	18
19	Laundry					19
20	Administrator	280	321	13,665	42.57	20
21	Assistant Administrator	1,824	2,080	46,585	22.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	746	822	10,209	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,088	1,230	21,733	17.67	29
30	Habilitation Aides (DD Homes)	13,487	15,167	154,706	10.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,383	25,263	$ 330,657 *	$ 13.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	69	$ 3,144	Ln.1,Col.3	35
36	Medical Director	22	2,200	Ln.9,Col.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	750	Ln.10,Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	2,394	Ln.10a,Col.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	75	4,860	Ln.10a,Col.3	46
47	Psychiatrist	4	423	Ln.10a,Col.3	47
48	Dental	75	2,802	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	306	$ 16,573		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	47	$ 2,800	Ln.10,Col.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	47	$ 2,800		53

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Albert Cueller III	Div. Director		$ 13,665
Angela Moore	Center Director		46,585
Nerlene Dossous	Staff Trng. Coord.		1,559
S. Tyler/V. Taylor	Service Coord.		11,407
H. Fly/B. Johnson-Baxter	Health Svcs. Coord.		1,654
Robbye Fulghum	Outreach Coord.		7,113
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,983

B. Administrative - Other

Description	Amount
Central Office - Management & General	$ 64,319
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 64,319

C. Professional Services

Vendor/Payee	Type	Amount
Washington, Pittman & McKeever	Auditors	$ 1,787
Verify	Computers	332
Others		1,972
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,091

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,237
Unemployment Compensation Insurance	2,865
FICA Taxes	24,466
Employee Health Insurance	19,326
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Income Plan	34,309
Retirement Plan Fees	999
Life Insurance	2,220
TOTAL (agree to Schedule V, line 22, col.8)	$ 87,422

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	473
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Staff Literature & Library	298
Membership Dues	1,863
Permits & Licenses	574
Professional Fees	26
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,234

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,586
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,586

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 07/01/09 Ending: 06/30/10

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. $ **1,349** 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. $ **37,144**
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? **15%**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **None**

(17) Has an audit been performed by an independent certified public accounting firm? **On-going**
Firm Name: **Washington, Pittman & McKeever, LLC**

(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 2010 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/02/09	281,784	PMTRX00006010	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354
12/11/09	296,776	PMTRX00006281	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354
03/30/10	306,244	PMTRX00006463	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354
05/31/10	311,938	PMTRX00006594	CARPET CLEANING	BROUWER BROTHERS	456
06/30/10	327,067	GLTRX00031690	Reclass RSD expenses	ADT SECURITY SERVICES INC.	896
					2,414

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION
FISCAL YEAR 2010 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Ref.	Vendor	Amount
11/29/09	69,661	GLTRX00029648	Variable Allocation - 11/09	Variable Allocation	122
12/29/09	69,661	GLTRX00029926	Variable Allocation - 12/09	Variable Allocation	358
01/29/10	69,661	GLTRX00030129	Variable Allocation - 01/10	Variable Allocation	1
02/28/10	69,661	GLTRX00030379	Variable Allocation - 02/10	Variable Allocation	22
06/30/10	327,067	GLTRX00031690	Reclass RSD expenses	RSD expenses	155
07/31/09	286,035	PMTRX00006091	E.E.A F/07/09	ALBERT CUELLER III	1
11/29/09	69,661	GLTRX00029648	Variable Allocation - 11/09	Variable Allocation	9
12/29/09	69,661	GLTRX00029926	Variable Allocation - 12/09	Variable Allocation	26
01/29/10	69,661	GLTRX00030129	Variable Allocation - 01/10	Variable Allocation	1
02/28/10	69,661	GLTRX00030379	Variable Allocation - 02/10	Variable Allocation	1
					696

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, 2010

HAMMOND HOUSE

DATE	CHECK NO.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	ACCOUNT 3310 15177081 Amount	ACCOUNT 3310 15178881 Amount	ACCOUNT 3310 15000031 Amount	ACCOUNT 3310 Total	Account 3330 Amount	In-State Travel & Seminar
09/30/09	289,928	120500	AAHSA REGISTRAR	AAHSA Service Coordinator Conference	Chicago, IL	G. Ellis/P. Halliburton	Service Coordinators	November 7-11, 2009	AAHSA		368.00		368.00		368.00
10/13/09	290,992	120728	INHAA	Illinois Nursing Home Administrators' Association Conference	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	November 3-4, 2009	INHAA	45.00			45.00		45.00
10/19/09	291,756	120932	IARF	IARF 34th Annual Conference and Expo	Peoria, IL	Angela Moore	Center Director	October 27-29, 2009	IARF	319.00			319.00		319.00
10/19/09	291,756	120932	IARF	IARF 34th Annual Conference and Expo	Peoria, IL	Albert Cueller III	Division Director	October 27-29, 2009	IARF		1.14	2.00	3.14		3.14
11/30/09	295,915	121885	I.C.A.N., INC.	ICAN Conference	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	October 31, 2009	ICAN			20.00	20.00		20.00
01/20/10	300,098	122604	ARC OF ILLINOIS	8th Annual QMRP Leadership Conference	Alsip, IL	Angela Moore	Center Director	January 26, 2010	ARC OF ILLINOIS	108.00			108.00		108.00
01/31/10	302,646		AMEX 08/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	July 29-30, 2009	Ada S. McKinley Community Services, Inc.		21.40	37.55	58.95		58.95
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		1.47	2.58	4.05		4.05
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		7.02	12.32	19.34		19.34
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		0.19	0.33	0.52		0.52
01/31/10	304,869		AMEX 12/09	Microsoft Excel Training	Rockford, IL	Albert Cueller III	Division Director	December 16-17, 2009	Ada S. McKinley Community Services, Inc.		0.83	1.46	2.29		2.29
01/31/10	304,888		AMEX 11/09	IARF 34th Annual Conference and Expo	Peoria, IL	Albert Cueller III & $ staff	Division Director & 4 staff	October 27-29, 2009	IARF			64.11	64.11		64.11
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	Robbye Fulghum	Outreach Coordinator/COS	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS			36.00	36.00		36.00
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	V. Taylor & S. Tyler	Service Coordinators	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS		72.00		72.00		72.00
03/23/10	305,955	124142	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	2010 HUD Training	Decatur, IL	Albert Cueller III	Division Director	May 4-7, 2010	ILLINOIS ASSOCIATION OF SERVICE COORDINATORS		10.26	18.00	28.26		28.26
06/30/10	326,391		AMEX 04/10	Business meal	Springfield, IL	Albert Cueller III	Division Director	April 28, 2010	Ada S. McKinley Community Services, Inc.		1.98	3.47	5.45		5.45
06/30/10	326,409		AMEX 06/10	Violence Prevention	Chicago, IL	Paulette Stallworth	Director - Habilitation Services	June 10, 2010	IANCICI	64.30			64.30		64.30
Various	Various	Various	Various	Business meals	Various	Various	Various						-	367.31	367.31
	TOTAL HAMMOND HOUSE									**$ 536.30**	**$ 484.29**	**$ 197.82**	**$ 1,218.41**	**$ 367.31**	**$ 1,585.72**

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2010 COST REPORT

DESCRIPTION	HAMMOND HOUSE
Mileage and auto rental	$ 3,214
Gasoline and vehicle repairs	1,532
Automobile insurance	861
	$ 5,607

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2010 COST REPORT

DESCRIPTION	HAMMOND HOUSE
Other Staff Expenses	$ 157
Client Benefits - Accident Insurance	67
Clothing & Personal Needs	3,164
Miscellaneous	15,092
Misc Exps-Service Coordinator	1,735
	$ 20,215