

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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 S. Morgan</u> <u>Chicago, IL</u> <u>60621</u> <small>Number City Zip Code</small></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: _____</p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table border="0"> <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>Eduardo S. Espiritu</u> Telephone Number: <u>(312) 385-2026</u> Email Address: _____</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>07/01/10</u> to <u>06/30/11</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"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>HANS J. SCHUSTER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>() ()</u> Fax # <u>() ()</u></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>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>HANS J. SCHUSTER</u> (Date) _____		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>() ()</u> Fax # <u>() ()</u>
<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 _____																																		
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Officer or Administrator of Provider	(Signed) _____																																			
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Paid Preparer	(Signed) _____																																			
	(Date) _____																																			
	(Print Name and Title) _____																																			
	(Firm Name & Address) _____																																			
	(Telephone) <u>() ()</u> Fax # <u>() ()</u>																																			

Facility Name & ID Number HAMMOND HOUSE

0030619 Report Period Beginning: 07/01/10 Ending: 06/30/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,356			5,356	13
14	TOTALS	5,356			5,356	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.83%

D. How many bed-hold days during this year were paid by the Department? 101 (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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 06/30/11

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

Facility Name & ID Number **HAMMOND HOUSE** # **0030619** Report Period Beginning: **07/01/10** Ending: **06/30/11**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	20,087	2,193	4,655	26,935	26,935		26,935			1
2	Food Purchase		35,340		35,340	35,340		35,340			2
3	Housekeeping		493		493	493		493			3
4	Laundry		1,339		1,339	1,339		1,339			4
5	Heat and Other Utilities			11,016	11,016	11,016		11,016			5
6	Maintenance	8,717	6,865	20,396	35,978	35,978		35,978			6
7	Other (specify):*			2,314	2,314	2,314		2,314			7
8	TOTAL General Services	28,804	46,230	38,381	113,415	113,415		113,415			8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400	2,400		2,400			9
10	Nursing and Medical Records	169,406	9,336	3,274	182,016	182,016	(2,529)	179,487			10
10a	Therapy			6,609	6,609	6,609		6,609			10a
11	Activities		416	3,151	3,567	3,567		3,567			11
12	Social Services	11,119			11,119	11,119		11,119			12
13	CNA Training										13
14	Program Transportation			2,484	2,484	2,484		2,484			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	180,525	9,752	17,918	208,195	208,195	(2,529)	205,666			16
	C. General Administration										
17	Administrative	94,984		49,961	144,945	144,945		144,945			17
18	Directors Fees										18
19	Professional Services			4,368	4,368	4,368		4,368			19
20	Dues, Fees, Subscriptions & Promotions			2,755	2,755	2,755		2,755			20
21	Clerical & General Office Expenses	8,495	3,130	17,484	29,109	29,109		29,109			21
22	Employee Benefits & Payroll Taxes			97,138	97,138	97,138		97,138			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,039	1,039	1,039	(469)	570			24
25	Other Admin. Staff Transportation			3,754	3,754	3,754		3,754			25
26	Insurance-Prop.Liab.Malpractice			4,144	4,144	4,144		4,144			26
27	Other (specify):*			5,248	5,248	5,248	(2,692)	2,556			27
28	TOTAL General Administration	103,479	3,130	185,891	292,500	292,500	(3,161)	289,339			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	312,808	59,112	242,190	614,110	614,110	(5,690)	608,420			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			26,123	26,123		26,123	(2,245)	23,878			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,959	22,959		22,959		22,959			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,877	4,877		4,877		4,877			34
35	Rent-Equipment & Vehicles			3,632	3,632		3,632		3,632			35
36	Other (specify):*											36
37	TOTAL Ownership			57,591	57,591		57,591	(2,245)	55,346			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			35,472	35,472		35,472		35,472			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,472	35,472		35,472		35,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	312,808	59,112	335,253	707,173		707,173	(7,935)	699,238			45

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

HAMMOND HOUSE

ID# 0030619

Report Period Beginning: 07/01/10

Ending: 06/30/11

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	(2,529)	10	12
13	Out-of-Town Travel	(469)	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	(2,998)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HAMMOND HOUSE# 0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(2,529)	0	0	0	0	0	0	0	0	0	0	(2,529)	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	(2,529)	0	0	0	0	0	0	0	0	0	0	(2,529)	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	(469)	0	0	0	0	0	0	0	0	0	0	(469)	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):*	(2,692)	0	0	0	0	0	0	0	0	0	0	(2,692)	27
28	TOTAL General Administration	(3,161)	0	0	0	0	0	0	0	0	0	0	(3,161)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,690)	0	0	0	0	0	0	0	0	0	0	(5,690)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HAMMOND HOUSE# 0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

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	(2,245)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(7,935)	0	0	0	0	0	0	0	0	0	0	(7,935)	45

Facility Name & ID Number

HAMMOND HOUSE

0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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:

07/01/10

Ending:

06/30/11

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:

07/01/10

Ending: 06/30/11

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	Ln. 17	Central Administration Exp.	Direct Cost	35,634,944	94	\$ 2,773,489	\$ 1,786,948	632,030	\$ 49,191	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,634,944	94	43,439		632,030	770	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					\$ 2,816,928	\$ 1,786,948		\$ 49,961	25

Facility Name & ID Number

HAMMOND HOUSE

0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	H.U.D.	X	Mortgage	\$2,657.00	12/01/86	\$ 334,060	\$ 243,300	12/1/2027	0.0925	\$ 22,959	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	\$ 243,300			\$ 22,959	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	\$ 243,300			\$ 22,959	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 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 2011 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:	2006	_____	8	FOR BHF USE ONLY		
	2007	_____	9			
	2008	_____	10			
	2009	_____	11			
	2010	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 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 2010 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 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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:

07/01/10

Ending:

06/30/11

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>ICF/DD</u>		<u>1984</u>	<u>\$ 19,952</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 19,952	3

Facility Name & ID Number HAMMOND HOUSE

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$ 321,479	4
5			1988	8,618	345	25	287	(58)	8,273	5
6			1999	13,000		10			13,000	6
7			2002	10,460	1,046	10	1,046		9,589	7
8			2004	2,165		5			2,165	8
Improvement Type**										
9	Interior repainting, kitchen, dining room, washroom laundry room, and bathroom repairs		2004	13,600	1,360	10	1,360		10,030	9
10	Upflow Bryant furnace		2005	2,495		5			2,495	10
11	Goodman 5-ton furnace		2005	2,550		5			2,550	11
12	Bathroom renovations		2008	21,151	2,115	10	2,115		8,020	12
13	Bathroom renovations - additional		2008	1,994	200	10	200		640	13
14	Commercial dishwasher		2010	4,921	984	5	984		1,107	14
15	Commercial dishwasher		2010	4,922	984	5	984		1,107	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **HAMMOND HOUSE**

0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$	\$ 413,916		\$ 17,911	\$ (2,245)	\$ 380,455	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 15,652	\$ 2,820	\$ 2,820	\$	5 Years	\$ 11,763	71
72	Current Year Purchases	2,894	416	416		5 Years	416	72
73	Fully Depreciated Assets	56,880				5 Years	56,880	73
74								74
75	TOTALS	\$ 75,426	\$ 3,236	\$ 3,236	\$		\$ 69,059	75

D. Vehicle Costs. (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	Staff transportation	2010 Dodge Grand Caravan SE	2011	\$ 9,283	\$ 2,731	\$ 2,731	\$	5 Years	\$ 2,862	76
77										77
78										78
79										79
80	TOTALS			\$ 9,283	\$ 2,731	\$ 2,731	\$		\$ 2,862	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)	\$ 518,577	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,878	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)	\$ 452,376	85

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

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

G. Construction-in-Progress

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

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>4,877</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>4,877</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A

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: \$ 2,424 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>100.63</u>	\$ <u>1,208</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>100.63</u>	\$ <u>1,208</u>	21

10. Effective dates of current rental agreement:

Beginning 07/01/10

Ending 06/30/11

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

Fiscal Year Ending Annual Rent

12. /2012 \$ _____

13. /2013 \$ _____

14. /2014 \$ _____

* 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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>We do not have CNA's, only Direct Service Persons or Habilitation Aides trained in a DHS certified program.</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

- (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.

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

	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 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.

Facility Name & ID Number HAMMOND HOUSE# 0030619Report Period Beginning: 07/01/10Ending: 06/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 1,218,503	1
2	Cash-Patient Deposits		164,942	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>193,593</u>)		7,629,215	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		174,725	6
7	Other Prepaid Expenses		224,454	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 9,411,839	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		506,507	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,754,105	14
15	Leasehold Improvements, at Historical Cost		2,094,563	15
16	Equipment, at Historical Cost		1,395,178	16
17	Accumulated Depreciation (book methods)		(8,205,550)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		314,981	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Bond Issue Costs, Security Deposits</u>		72,797	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 4,888,080	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 14,299,919	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 2,343,925	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		169,673	28
29	Short-Term Notes Payable		15,941	29
30	Accrued Salaries Payable		2,434,748	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,770	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		79,041	35
Other Current Liabilities(specify):				
36	<u>Unfunded Pension Liabilities</u>		172,723	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 5,229,821	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,683,233	40
41	Bonds Payable		900,000	41
42	Deferred Compensation		34,407	42
Other Long-Term Liabilities(specify):				
43	<u>Pension Benefit Liabilities</u>		4,434,836	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 7,052,476	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 12,282,297	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,017,622	\$ 2,017,622	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,017,622	\$ 14,299,919	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

	1 Total	
1 Balance at Beginning of Year, as Previously Reported	\$ (140,555)	1
2 Restatements (describe):		2
3 <u>Beginning Balance - Other Operating Units</u>	284,919	3
4 <u>Prior Year's Adjustment</u>	1,620,122	4
5		5
6 Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,764,486	6
A. Additions (deductions):		
7 NET Income (Loss) (from page 19, line 43)	79,895	7
8 Aquisitions of Pooled Companies		8
9 Proceeds from Sale of Stock		9
10 Stock Options Exercised		10
11 Contributions and Grants		11
12 Expenditures for Specific Purposes		12
13 Dividends Paid or Other Distributions to Owners	()	13
14 Donated Property, Plant, and Equipment		14
15 Other (describe) <u>Operating Income-Other Operating Units</u>	173,241	15
16 Other (describe)		16
17 TOTAL Additions (deductions) (sum of lines 7-16)	\$ 253,136	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)	\$ 2,017,622	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HAMMOND HOUSE# 0030619Report Period Beginning: 07/01/10Ending: 06/30/11

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	\$ 676,664	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 676,664	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	108,827	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)	\$ 108,827	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Insurance Proceeds, miscellaneous</u>	1,747	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,747	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 787,238	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	113,415	31
32	Health Care	208,195	32
33	General Administration	292,670	33
B. Capital Expense			
34	Ownership	57,591	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,472	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 707,343	40
41	Income before Income Taxes (line 30 minus line 40)**	79,895	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 79,895	43

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

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

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

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

Facility Name & ID Number **HAMMOND HOUSE**

0030619

Report Period Beginning:

07/01/10

Ending:

06/30/11

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	181	5,020	24.37	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	312	11,119	31.23	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,596	20,087	11.04	14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers	455	8,717	16.86	17
18	Housekeepers				18
19	Laundry				19
20	Administrator	296	14,441	42.60	20
21	Assistant Administrator	1,781	45,506	22.39	21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	621	8,495	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	1,754	35,037	17.67	29
30	Habilitation Aides (DD Homes)	14,331	164,386	10.20	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	21,327	312,808 *	13.01	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	102	\$ 4,655	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	8	745	Ln.10,Col.3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	56	2,541	Ln.10a,Col.3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psychologist</u>	63	4,068	Ln.10a,Col.3 46
47	<u>Psychiatrist</u>			Ln.10a,Col.3 47
48	<u>Dental</u>	67	2,529	Ln.10,Col.3 48
49	TOTAL (lines 35 - 48)	320	\$ 16,938	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Description			Description	Amount	Description	Amount	
Albert Cueller III	Div. Director			\$ 4,010	Workers' Compensation Insurance	\$ 6,648	IDPH License Fee	\$	
Linda Darling	Residential Svcs. Director			10,431	Unemployment Compensation Insurance	18,091	Advertising: Employee Recruitment	179	
Angela Moore	Center Director			45,506	FICA Taxes	23,114	Health Care Worker Background Check		
S. Tyler/V. Taylor	Service Coord.			11,107	Employee Health Insurance	18,937	(Indicate # of checks performed _____)		
Valerie Bright	Health Svcs. Coord.			13,192	Employee Meals		Patient Background Checks		
Robbye Fulghum	Outreach Coord.			10,738	Illinois Municipal Retirement Fund (IMRF)*		Staff Literature & Library	148	
					Retirement Income Plan	27,323	Membership Dues	2,008	
					Retirement Plan Fees	908	Permits & Licenses	385	
					Life Insurance	2,117	Professional Fees	35	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 94,984					
B. Administrative - Other									
Description				Amount					
Central Office - Management & General				\$ 49,961					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 49,961					
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Washington, Pittman & McKeever	Auditors		\$ 1,146	N/A		\$	Out-of-State Travel	\$	
Verify	Computers		154						
Others			3,068				In-State Travel	570	
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 4,368	TOTAL	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 570	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HAMMOND HOUSE# 0030619Report Period Beginning: 07/01/10Ending: 06/30/11**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. \$ _____ 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,472
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? 40%
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. \$ _____
- (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 2011 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
07/12/10	322,625	PMTRX00006662	Purchases	LUX SECURITY SYSTEMS, CO.	\$ 354
08/31/10	329,231	PMTRX00006804	Purchases	LUX SECURITY SYSTEMS, CO.	354
11/17/10	334,947	PMTRX00006941	Purchases	LUX SECURITY SYSTEMS, CO.	354
04/12/11	347,193	PMTRX00007212	Purchases	LUX SECURITY SYSTEMS, CO.	354
06/30/11	361,195	GLTRX00034920		Reallocate RSD expenses	898
					\$ 2,314

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
 SCHEDULE XIX-G (Page 21) - ANALYSIS OF IN-STATE TRAVEL AND SEMINAR - Account 331C
 FOR THE FISCAL YEAR ENDED JUNE 30, 2011

HAMMOND HOUSE

DATE	CHECK NO.	Check No.	PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	ACCOUNT 3310				Account	In-State Travel & Seminar
										15177081	15178881	15000031	Total	3330	
										Amount	Amount	Amount		Amount	
10/21/10	332,274	128578	CROWNE PLAZA	2010 Annual Convention & Trade Show	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	11/2-3/10	IL Nursing Home Administrators' Asso.	47.04			47.04		47.04
10/21/10	332,277	128591	INHAA	2010 Annual Convention & Trade Show	Springfield, IL	Paulette Stallworth	Director - Habilitation Services	11/2-3/10	IL Nursing Home Administrators' Asso.	45.00			45.00		45.00
03/22/11	345,472	131784	FRED PRYOR SEMINARS	Management Skills for Secretaries, Admin. Assistants & Support Staff	Oakbrook Terrace, IL	Marshon Sutton	Administrative Assistant	April 6, 2011	Ada S. McKinley Community Services, Inc.	18.76			18.76		18.76
02/07/11	341,290	130778	NATIONAL RESOURCES FOR HOUSING	HUD Update, EIV & MOR Training	Chicago, IL	Robbye Fulghum	Outreach Coordinator/COS	February 22, 2011	HUD			55.80	55.80		55.80
02/07/11	341,290	130778	NATIONAL RESOURCES FOR HOUSING	HUD Update, EIV & MOR Training	Chicago, IL	Linda Darling	Director - Residential	February 22, 2011	HUD		15.74	27.90	43.64		43.64
01/18/11	340,116	130356	AMERICAN RED CROSS OF GREATER CHGO	AP FY11 Cert	Chicago, IL	Paulette Stallworth	Director - Habilitation Services	November 11, 2010	Ada S. McKinley Community Services, Inc.	18.00			18.00		18.00
02/28/11	344,830	131449	CORPORATE TRAINING CENTER	IL State Food Service course	Chicago, IL	Kelle Warnsley		March 3, 2011	Ada S. McKinley Community Services, Inc.	149.00			149.00		149.00
03/31/11	346,444	132087	AMERICAN RED CROSS OF GREATER CHGO	First Aid, Adult CPR	Chicago, IL	C. Vickers & T. Kelly		October 25, 2010	Ada S. McKinley Community Services, Inc.	20.00			20.00		20.00
02/28/11	345,145	131564	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	HUD Training	Chicago, IL	Robbye Fulghum	Outreach Coordinator/COS	March 26, 2011	HUD			50.00	50.00		50.00
06/30/11	355,469	134266	AMERICAN RED CROSS OF GREATER CHGO	CPR/First Aid	Chicago, IL	Robbye Fulghum	Outreach Coordinator/COS	June 8, 2011	Ada S. McKinley Community Services, Inc.			1.60	1.60		1.60
Various	Various	Various	Various	Business meals	Various	Various	Various						-	120.98	120.98
TOTAL HAMMOND HOUSE										\$ 297.80	\$ 15.74	\$ 135.30	\$ 448.84	\$ 120.98	\$ 569.82

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2011 COST REPORT

DESCRIPTION	HAMMOND
Mileage and auto rental	\$ 2,499
Gasoline and vehicle repairs	466
Automobile insurance	789
	\$ 3,754

ADA S. MCKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2011 COST REPORT

DESCRIPTION	HAMMOND
Other Staff Expenses	\$ 133
Other Agency Meetings	821
Client Benefits - Accident Insurance	67
Clothing & Personal Needs	2,692
Miscellaneous	538
Misc Exps-Service Coordinator	997
	\$ 5,248