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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Eduardo S. Espiritu **Telephone Number:** (312) 385-2026
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 07/01/11 to 06/30/12 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: 07/01/11 Ending: 06/30/12

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	5,304			5,304	13
14	TOTALS	5,304			5,304	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.88%

D. How many bed-hold days during this year were paid by the Department?
105 (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 [X] NO [ ]

Tax Year: N/A Fiscal Year: 06/30/12

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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	23,068	2,916	3,565	29,549		29,549		29,549			1
2	Food Purchase		34,997		34,997		34,997		34,997			2
3	Housekeeping		320		320		320		320			3
4	Laundry		1,209		1,209		1,209		1,209			4
5	Heat and Other Utilities			12,576	12,576		12,576		12,576			5
6	Maintenance	12,389	5,655	33,873	51,917		51,917		51,917			6
7	Other (specify):*			2,745	2,745		2,745		2,745			7
8	**TOTAL General Services**	35,457	45,097	52,759	133,313		133,313		133,313			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	175,298	9,214	3,313	187,825		187,825	(3,060)	184,765			10
10a	Therapy			7,995	7,995		7,995		7,995			10a
11	Activities		27	2,706	2,733		2,733		2,733			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			2,755	2,755		2,755		2,755			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	175,298	9,241	20,369	204,908		204,908	(3,060)	201,848			16
	C. General Administration											
17	Administrative	94,668		57,704	152,372		152,372		152,372			17
18	Directors Fees											18
19	Professional Services			4,481	4,481		4,481		4,481			19
20	Dues, Fees, Subscriptions & Promotions			2,495	2,495		2,495		2,495			20
21	Clerical & General Office Expenses	6,706	3,928	19,522	30,156		30,156		30,156			21
22	Employee Benefits & Payroll Taxes			95,218	95,218		95,218		95,218			22
23	Inservice Training & Education			540	540		540		540			23
24	Travel and Seminar			1,268	1,268		1,268	(771)	497			24
25	Other Admin. Staff Transportation			4,907	4,907		4,907		4,907			25
26	Insurance-Prop.Liab.Malpractice			4,209	4,209		4,209		4,209			26
27	Other (specify):*			13,455	13,455		13,455	(2,335)	11,120			27
28	**TOTAL General Administration**	101,374	3,928	203,799	309,101		309,101	(3,106)	305,995			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	312,129	58,266	276,927	647,322		647,322	(6,166)	641,156			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:** 07/01/11 **Ending:** 06/30/12

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			18,714	18,714		18,714	(1,152)	17,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,097	22,097		22,097		22,097			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,877	4,877		4,877		4,877			34
35	Rent-Equipment & Vehicles			2,378	2,378		2,378		2,378			35
36	Other (specify):*											36
37	**TOTAL Ownership**			48,066	48,066		48,066	(1,152)	46,914			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			38,818	38,818		38,818		38,818			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			38,818	38,818		38,818		38,818			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	312,129	58,266	363,811	734,206		734,206	(7,318)	726,888			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: 07/01/11 Ending: 06/30/12

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	(1,152)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,335)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,487)		$	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))**	$ (3,487)		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

HAMMOND HOUSE

ID# 0030619

Report Period Beginning: 07/01/11

Ending: 06/30/12

	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	(3,060)	10	12
13	Out-of-Town Travel	(771)	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**	(3,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HAMMOND HOUSE **#** 0030619 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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	(3,060)	0	0	0	0	0	0	0	0	0	0	(3,060)	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**	(3,060)	0	0	0	0	0	0	0	0	0	0	(3,060)	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	(771)	0	0	0	0	0	0	0	0	0	0	(771)	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):*	(2,335)	0	0	0	0	0	0	0	0	0	0	(2,335)	27
28	**TOTAL General Administration**	(3,106)	0	0	0	0	0	0	0	0	0	0	(3,106)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,166)	0	0	0	0	0	0	0	0	0	0	(6,166)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HAMMOND HOUSE **#** 0030619 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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	(1,152)	0	0	0	0	0	0	0	0	0	0	(1,152)	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**	(1,152)	0	0	0	0	0	0	0	0	0	0	(1,152)	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)**	(7,318)	0	0	0	0	0	0	0	0	0	0	(7,318)	45

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

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 [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: 07/01/11 Ending: 06/30/12

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: 07/01/11 Ending: 06/30/12

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: 1359 W. Washington Blvd.
City / State / Zip Code: Chicago, IL 60607
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	35,049,164	89	$ 3,038,441	$ 1,425,080	657,788	$ 57,024	1
2	Ln. 17	Central Administration Exp.	Direct Cost	35,049,164	89	36,234		657,788	680	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					$ 3,074,675	$ 1,425,080		$ 57,704	25

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	$ 233,516	12/1/2027	0.0925	$ 22,097	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	$ 233,516			$ 22,097	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	$ 233,516			$ 22,097	15

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

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

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

Facility Name & ID Number HAMMOND HOUSE **#** 0030619 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 07/01/11 Ending: 06/30/12

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. [ ] (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: 07/01/11 Ending: 06/30/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 6,561	25	$ 5,467	$ (1,094)	$	4
5				1988	8,618	345	25	287	(58)		5
6				1999	13,000		10				6
7				2002	10,460	872	10	872			7
8				2004	2,165		5				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			10
11	Upflow Bryant furnace			2005	2,495		5				11
12	Goodman 5-ton furnace			2005	2,550		5				12
13	Bathroom renovations			2008	21,151	2,115	10	2,115			13
14	Bathroom renovations - additional			2008	1,994	200	10	200			14
15	Commercial dishwasher			2010	4,921	984	5	984			15
16	Commercial dishwasher			2010	4,922	984	5	984			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: 07/01/11 Ending: 06/30/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 13,421		$ 12,269	$ (1,152)	$	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: 07/01/11 Ending: 06/30/12

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	$ 15,479	$ 2,850	$ 2,850	$	5 Years	$ 12,132	71
72	Current Year Purchases	2,465	300	300		5 Years	300	72
73	Fully Depreciated Assets	18,916	286	286		5 Years	19,043	73
74								74
75	TOTALS	$ 36,860	$ 3,436	$ 3,436	$		$ 31,475	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	$ 1,857	$ 1,857	$	5 Years	$ 4,719	76
77										77
78										78
79										79
80	TOTALS			$ 9,283	$ 1,857	$ 1,857	$		$ 4,719	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)	$ 480,011	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,714	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 17,562	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,152)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 36,194	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: 07/01/11 Ending: 06/30/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Samaritas, Inc. - Residential Services 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:				$ 4,877			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 4,877 **			7

10. Effective dates of current rental agreement:
    Beginning 07/01/11
    Ending 06/30/12

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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 [X] NO Terms: *

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: $ 1,171 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	$ 100.63	$ 1,207	17
18					18
19					19
20					20
21	TOTAL		$ 100.63	$ 1,207	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: 07/01/11 Ending: 06/30/12

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?
   - [ ] YES
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

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:** 07/01/11 **Ending:** 06/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/12 **(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	$	$ 467,210	1
2	Cash-Patient Deposits		171,261	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,467)		6,974,499	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		5,000	5
6	Prepaid Insurance		169,593	6
7	Other Prepaid Expenses		195,967	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 7,983,530	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		522,734	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,883,105	14
15	Leasehold Improvements, at Historical Cost		2,094,563	15
16	Equipment, at Historical Cost		1,584,157	16
17	Accumulated Depreciation (book methods)		(8,592,450)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		231,890	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Costs, Security Deposits		40,675	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 4,720,173	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 12,703,703	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,332,888	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		171,215	28
29	Short-Term Notes Payable		6,600	29
30	Accrued Salaries Payable		1,287,120	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,284	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		1,253	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 3,812,360	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,738	39
40	Mortgage Payable		1,624,821	40
41	Bonds Payable		750,000	41
42	Deferred Compensation		52,016	42
	Other Long-Term Liabilities(specify):			
43	Pension Benefit Liabilities		8,646,716	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,076,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 14,888,651	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,184,948	$ (2,184,948)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,184,948	$ 12,703,703	48

***(See instructions.)**

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (60,660)	1
2	Restatements (describe):		2
3	**Beginning Balance - Other Operating Units**	2,078,282	3
4	**Prior Year's Adjustment**	(118,033)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,899,589	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,223	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**	256,136	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 285,359	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)**	$ 2,184,948	24 *

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 667,145	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 667,145	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	94,166	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)**	$ 94,166	23
	D. Non-Operating Revenue		
24	Contributions	500	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 500	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Insurance Proceeds, Miscellaneous	1,618	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,618	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 763,429	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	133,313	31
32	Health Care	204,908	32
33	General Administration	309,101	33
	B. Capital Expense		
34	Ownership	48,066	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 734,206	40
41	**Income before Income Taxes (line 30 minus line 40)****	29,223	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 29,223	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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: 07/01/11 Ending: 06/30/12

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	434	488	12,046	24.68	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					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,832	2,089	23,068	11.04	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	647	735	12,389	16.86	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	351	403	17,153	42.56	20
21	Assistant Administrator	1,867	2,129	47,691	22.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	490	540	6,706	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	1,493	1,688	29,824	17.67	29
30	Habilitation Aides (DD Homes)	14,232	16,005	163,252	10.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,346	24,077	$ 312,129 *	$ 12.96	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		$ 3,565	Ln.1,Col.3	35
36	Medical Director		3,600	Ln.9,Col.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		253	Ln.10,Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		1,989	Ln.10a,Col.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist		5,796	Ln.10a,Col.3	46
47	Psychiatrist		210	Ln.10a,Col.3	47
48	Dental		3,060	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)		$ 18,473		49

C. CONTRACT NURSES

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

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Darling	Residential Svcs. Director		$ 17,153
Angela Moore	Center Director		47,691
A. Tyler	Service Coord.		9,576
Valerie Bright	Health Svcs. Coord.		10,039
Robbye Fulghum	Outreach Coord.		10,209
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,668

B. Administrative - Other

Description	Amount
Central Office - Management & General	$ 57,704
TOTAL (agree to Schedule V, line 17, col. 3)	$ 57,704
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Washington, Pittman & McKeever	Auditors	$ 1,063
Verify	Computers	224
Others		3,194
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,481

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,056
Unemployment Compensation Insurance	10,386
FICA Taxes	23,284
Employee Health Insurance	21,351
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Income Plan	28,959
Retirement Plan Fees	887
Life Insurance	2,295
TOTAL (agree to Schedule V, line 22, col.8)	$ 95,218

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Staff Literature & Library	78
Membership Dues	1,965
Permits & Licenses	385
Professional Fees	67
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,495

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	497
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 497

**See instructions.

Facility Name & ID Number HAMMOND HOUSE # 0030619 Report Period Beginning: 07/01/11 Ending: 06/30/12

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:** 07/01/11 **Ending:** 06/30/12

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. $ **383** 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. $ **38,818**
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? **36%**
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: **Blackman Kallick, LLP**

(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 2012 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
08/18/11	358,292	PMTRX00007465	Purchases	LUX SECURITY SYSTEMS, CO.	700
03/22/12	375,924	PMTRX00007878	Purchases	LUX SECURITY SYSTEMS, CO.	354
03/31/12	378,137	GLTRX00036556		LUX SECURITY SYSTEMS, CO.	354
03/31/12	378,138	GLTRX00036556		LUX SECURITY SYSTEMS, CO.	354
03/31/12	378,139	GLTRX00036556		LUX SECURITY SYSTEMS, CO.	354
03/31/12	378,297	GLTRX00036570		ADT SECURITY SERVICES INC.	629
					2,745

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, 2012

HAMMOND HOUSE

DATE	JE No.	Check No.	Orig. Audit Trail	Particulars	PAYEE
09/30/11	363,485	134312	GLTRX00035154	Summer Conference	IL Nursing Home Administrator's Association
04/25/12	378,778	140002	PMTRX00007942	Room - ISCC Conference	MARRIOTT INDIANAPOLIS DOWNTOWN
05/31/12	383,033	Log 780	PMTRX00008041	Registration	HIXON TRAINING CONSULTING
05/31/12	383,033	Log 780	PMTRX00008041	Registration	HIXON TRAINING CONSULTING
03/31/12	378,057	139769	PMTRX00007920	Authorized Provider Processing Fee	AMERICAN RED CROSS
04/25/12	378,777	140001	PMTRX00007942	Room - ISCC Conference	MARRIOTT INDIANAPOLIS DOWNTOWN
04/25/12	378,794	140084	PMTRX00007942	Per diem - ISCC Conference	APRIL TYLER
Various	Various	Various			
	TOTAL HAMMOND HOUSE				

CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	In-State Travel & Seminar
INHAA Summer Conference	Bloomington, IL	Linda Darling	Director - Habilitation Services	08/10-11/11	INHAA	30.50
IL Service Coordinators Conference	Indianapolis, IN	Robbye Fulghum	Outreach Coordinator/COS	05/01-03/12	IL Association of Service Coordinators	108.81
TRACS 202-D Training	Countryside, IL	Linda Darling	Director - Habilitation Services	July 12, 2012	Ada S. McKinley Community Services, Inc.	49.80
TRACS 202-D Training	Countryside, IL	Robbye Fulghum	Outreach Coordinator/COS	July 12, 2012	Ada S. McKinley Community Services, Inc.	49.80
	Chicago, IL	Roseann Michaels		August 16, 2011	Ada S. McKinley Community Services, Inc.	5.40
IL Service Coordinators Conference	Indianapolis, IN	April Tyler	Service Coordinator	05/01-03/12	IL Association of Service Coordinators	36.27
IL Service Coordinators Conference	Indianapolis, IN	April Tyler	Service Coordinator	05/01-03/12	IL Association of Service Coordinators	43.00
						173.69
						$ 497.27

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2012 COST REPORT

DESCRIPTION	HAMMOND HOUSE
Mileage and auto rental	$ 4,000
Gasoline and vehicle repairs	131
Automobile insurance	776
	$ 4,907

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2012 COST REPORT

DESCRIPTION	HAMMOND HOUSE
Other Staff Expenses	$ 104
Other Agency Meetings	555
Client Benefits - Accident Insurance	23
Clothing & Personal Needs	2,334
Miscellaneous	4,291
Misc Exps-Service Coordinator	522
Provision for Doubtful Accounts	5,626
	$ 13,455