		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

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: 36-2144820-002

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	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/08 to 06/30/09 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 # ( )

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

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: 07/01/08 Ending: 06/30/09

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,411			5,411	13
14	TOTALS	5,411			5,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.83%

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

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

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A Fiscal Year: 06/30/09

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	20,579	2,963	3,257	26,799		26,799		26,799			1
2	Food Purchase		45,633		45,633		45,633		45,633			2
3	Housekeeping	21,988	366		22,354		22,354		22,354			3
4	Laundry		1,045		1,045		1,045		1,045			4
5	Heat and Other Utilities			14,533	14,533		14,533		14,533			5
6	Maintenance	14,406	6,107	15,335	35,848		35,848		35,848			6
7	Other (specify):*			2,151	2,151		2,151		2,151			7
8	**TOTAL General Services**	56,973	56,114	35,276	148,363		148,363		148,363			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	162,231	11,346	2,385	175,962		175,962	(1,560)	174,402			10
10a	Therapy			18,507	18,507		18,507		18,507			10a
11	Activities		206	5,468	5,674		5,674		5,674			11
12	Social Services	12,999			12,999		12,999		12,999			12
13	CNA Training		425	161	586		586		586			13
14	Program Transportation			1,301	1,301		1,301		1,301			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	175,230	11,977	30,222	217,429		217,429	(1,560)	215,869			16
	C. General Administration											
17	Administrative	75,356		61,104	136,460		136,460		136,460			17
18	Directors Fees											18
19	Professional Services			7,156	7,156		7,156		7,156			19
20	Dues, Fees, Subscriptions & Promotions			3,145	3,145		3,145		3,145			20
21	Clerical & General Office Expenses	10,331	5,367	12,476	28,174		28,174		28,174			21
22	Employee Benefits & Payroll Taxes			78,787	78,787		78,787		78,787			22
23	Inservice Training & Education			1,213	1,213		1,213		1,213			23
24	Travel and Seminar			3,139	3,139		3,139	(1,208)	1,931			24
25	Other Admin. Staff Transportation			6,046	6,046		6,046		6,046			25
26	Insurance-Prop.Liab.Malpractice			4,422	4,422		4,422		4,422			26
27	Other (specify):*	185		12,889	13,074		13,074	(2,579)	10,495			27
28	**TOTAL General Administration**	85,872	5,367	190,377	281,616		281,616	(3,787)	277,829			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	318,075	73,458	255,875	647,408		647,408	(5,347)	642,061			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: 07/01/08 Ending: 06/30/09

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			22,669	22,669		22,669	(2,245)	20,424			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,460	24,460		24,460		24,460			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			13,015	13,015		13,015		13,015			34
35	Rent-Equipment & Vehicles			7,871	7,871		7,871		7,871			35
36	Other (specify):*											36
37	TOTAL Ownership			68,015	68,015		68,015	(2,245)	65,770			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			36,028	36,028		36,028		36,028			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			36,028	36,028		36,028		36,028			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	318,075	73,458	359,918	751,451		751,451	(7,592)	743,859			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: 07/01/08 Ending: 06/30/09

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,245)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,579)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,824)		$	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))**	$ (4,824)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Hammond House

ID# 0030619

Report Period Beginning: 07/01/08

Ending: 06/30/09

	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	(1,560)	10	12
13	Out-of-Town Travel	(1,208)	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**	(2,768)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,560)	0	0	0	0	0	0	0	0	0	0	(1,560)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,560)	0	0	0	0	0	0	0	0	0	0	(1,560)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,208)	0	0	0	0	0	0	0	0	0	0	(1,208)	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):*	(2,579)	0	0	0	0	0	0	0	0	0	0	(2,579)	27
28	**TOTAL General Administration**	(3,787)	0	0	0	0	0	0	0	0	0	0	(3,787)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,347)	0	0	0	0	0	0	0	0	0	0	(5,347)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(7,592)	0	0	0	0	0	0	0	0	0	0	(7,592)	45

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Moore House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Voluntary Health
		Davis House	Chicago, IL	Ada S. Mckinley	Chicago, IL	and Welfare
		Knight House	Chicago, IL	Ada S. Mckinley	Chicago, IL	Agency
		Danforth House	Chicago, IL	Ada S. Mckinley	Chicago, IL	

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

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

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

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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: 07/01/08 Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Ada S. McKinley Community Services, Inc.
Street Address: 725 S. Wells St.
City / State / Zip Code: Chicago, IL
Phone Number: (312) 385-2000
Fax Number: (312) 554-8161

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Ln. 17	Central Administration Exp.	Direct Cost	36,235,713	97	$ 3,235,426	$ 1,759,032	667,678	$ 59,616	1
2	Ln. 17	Central Administration Exp.	Direct Cost	36,235,713	97	80,747		667,678	1,488	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					$ 3,316,173	$ 1,759,032		$ 61,104	25

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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**		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	$ 260,360	12/1/2027	0.0925	$ 24,460	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	$ 260,360			$ 24,460	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	$ 260,360			$ 24,460	15

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

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

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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

1. Real Estate Tax accrual used on 2008 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 2009 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:

2004		8
2005		9
2006		10
2007		11
2008		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2008	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 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 2008 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 2008.

	(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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 07/01/08 Ending: 06/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,680 B. General Construction Type: Exterior _____ 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. [X] (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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	ICF/DD		1984	$ 19,952	1
2					2
3	TOTALS			$ 19,952	3

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15		1986	1986	$ 328,040	$ 13,122	25	$ 10,935	$ (2,187)	$ 290,863	4
5				1988	8,618	345	25	287	(58)	7,468	5
6				1999	13,000	650	10	650		13,000	6
7				2002	10,460	1,046	10	1,046		7,496	7
8				2004	2,165	162	5	162		2,165	8
	Improvement Type**										
9	Interior repainting, kitchen, dining room, washroom,										9
10	laundry room, and bathroom repairs			2004	13,600	1,360	10	1,360		7,310	10
11	Upflow Bryant furnace			2005	2,495	499	5	499		2,349	11
12	Goodman 5-ton furnace			2005	2,550	510	5	510		2,444	12
13	Bathroom renovations			2008	21,151	2,115	10	2,115		3,789	13
14	Bathroom renovations - additional			2008	1,994	199	10	199		241	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 404,073	$ 20,008		$ 17,763	$ (2,245)	$ 337,125	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: 07/01/08 Ending: 06/30/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 9,635	$ 1,761	$ 1,761	$	5 Years	$ 5,674	71
72	Current Year Purchases	5,652	900	900		5 Years	900	72
73	Fully Depreciated Assets	39,471				5 Years	39,471	73
74								74
75	TOTALS	$ 54,758	$ 2,661	$ 2,661	$		$ 46,045	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 478,783	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,669	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,424	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)	$ 383,170	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: 07/01/08 Ending: 06/30/09

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 13,015			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 13,015 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

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

10. Effective dates of current rental agreement:
Beginning 07/01/08
Ending 06/30/09

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

	Fiscal Year Ending	Annual Rent
12.	/2010	$
13.	/2011	$
14.	/2012	$

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: $ 3,740 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	$ 344.28	$ 4,131	17
18					18
19					19
20					20
21	TOTAL		$ 344.28	$ 4,131	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: 07/01/08 Ending: 06/30/09

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

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

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		425		425
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		161		161
8	CNA Competency Tests				
9	TOTALS	$	$ 586	$	$ 586
10	SUM OF line 9, col. 1 and 2 (e)	$ 586			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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.

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/09 (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	$	$ 1,428,504	1
2	Cash-Patient Deposits		170,752	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 275,362)		6,626,092	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		85,669	6
7	Other Prepaid Expenses		79,198	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 8,390,215	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		343,471	11
12	Long-Term Investments			12
13	Land		955,499	13
14	Buildings, at Historical Cost		7,528,685	14
15	Leasehold Improvements, at Historical Cost		2,082,363	15
16	Equipment, at Historical Cost		4,492,048	16
17	Accumulated Depreciation (book methods)		(10,590,417)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		216,911	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Costs, Security Deposits		91,904	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 5,120,464	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 13,510,679	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,803,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		173,022	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		1,632,065	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		14,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		86,692	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 4,709,197	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,785,781	40
41	Bonds Payable		1,200,000	41
42	Deferred Compensation		11,055	42
	Other Long-Term Liabilities(specify):			
43	Pension Benefit Liability		3,232,691	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,229,527	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 10,938,724	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,571,955	$ 2,571,955	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,571,955	$ 13,510,679	48

*(See instructions.)

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (213,917)	1
2	Restatements (describe):		2
3	Beginning Balance - Other Operating Units	1,914,671	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,700,754	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	62,882	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	808,319	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 871,201	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)**	$ 2,571,955	24 *

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 708,580	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 708,580	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	102,582	10
11	CNA Training Reimbursements	3,154	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)**	$ 105,736	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		17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 814,333	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	148,363	31
32	Health Care	217,429	32
33	General Administration	281,616	33
	B. Capital Expense		
34	Ownership	68,015	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,028	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 751,451	40
41	**Income before Income Taxes (line 30 minus line 40)****	62,882	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 62,882	43

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

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

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

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	537	604	14,907	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	365	416	12,999	31.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,824	2,080	20,579	9.89	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	752	854	14,406	16.87	17
18	Housekeepers	1,824	2,080	21,989	10.57	18
19	Laundry					19
20	Administrator	286	327	13,932	42.61	20
21	Assistant Administrator	1,824	2,080	43,018	20.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	755	832	10,331	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	921	1,042	18,405	17.66	29
30	Habilitation Aides (DD Homes)	12,843	14,443	147,324	10.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Security Guard	19	19	185	9.74	33
34	TOTAL (lines 1 - 33)	21,950	24,777	$ 318,075 *	$ 12.84	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	71	$ 3,257	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	9	825	Ln.10,Col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	57	2,562	Ln.10a,Col.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	135	8,775	Ln.10a,Col.3	46
47	Psychiatrist	72	7,170	Ln.10a,Col.3	47
48	Dental	42	1,560	Ln.10,Col.3	48
49	TOTAL (lines 35 - 48)	410	$ 26,549		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Albert Cueller III	Div. Director		$ 13,932
Angela Moore	Center Director		43,018
Nerlene Dossous	Staff Trng. Coord.		4,743
Gwendolyn Ellis	Service Coord.		7,238
Pamela Halliburton	Service Coord.		6,425
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,356

B. Administrative - Other

Description	Amount
Central Office - Management & General	$ 61,104
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 61,104

C. Professional Services

Vendor/Payee	Type	Amount
Washington, Pittman & McKeever	Auditors	$ 1,672
Nechin Enterprises	HUD Consultant	2,714
Verify	Computers	173
Linda Darling	Habilitation Cons.	650
Others		1,947
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 7,156

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 3,159
Unemployment Compensation Insurance	
FICA Taxes	23,621
Employee Health Insurance	19,066
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Income Plan	28,745
Retirement Plan Fees	935
Life Insurance	3,261
TOTAL (agree to Schedule V, line 22, col.8)	$ 78,787

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	397
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Staff Literature & Library	184
Membership Dues	2,030
Permits & Licenses	464
Professional Fees	70
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,145

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,931
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,931

**See instructions.

Facility Name & ID Number Hammond House # 0030619 Report Period Beginning: 07/01/08 Ending: 06/30/09

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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: 07/01/08 Ending: 06/30/09

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,575** Line **27**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **36,028**
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? **18%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **None**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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 2009 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Reference	Vendor	Amount
10/09/08	255,637	PMTRX00005423	ACCT. #2808	LUX SECURITY SYSTEMS, CO.	354.00
07/03/08	244,396	PMTRX00005121	ACCT. #2808	LUX SECURITY SYSTEMS, CO.	354.00
07/30/08	247,673	PMTRX00005205	ACCT. #2808	LUX SECURITY SYSTEMS, CO.	700.00
11/13/08	258,883	PMTRX00005497	ACCT. #2808	LUX SECURITY SYSTEMS, CO.	354.00
04/24/09	275,074	PMTRX00005858	ACCT. #2942	LUX SECURITY SYSTEMS, CO.	354.00
06/30/09	285,511	GLTRX00028581	Allocate RSD expenses	LUX SECURITY SYSTEMS, CO.	35.38
					$ 2,151.38

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 23 - INSERVICE TRAINING AND EDUCATION
FISCAL YEAR 2009 COST REPORT

HAMMOND HOUSE

Trx Date	Jrnl No.	Orig. Audit Trail	Dist. Ref.	Vendor	Amount
12/29/08	69,661	GLTRX00026379	Variable Allocation - 12/08	Variable Allocation	$ 731.54
12/31/08	265,722	GLTRX00026405	Exp ck107347-Hyatt Regency	Hyatt Regency	37.28
01/29/09	69,661	GLTRX00026686	Variable Allocation - 01/09	Variable Allocation	(11.77)
01/31/09	268,009	GLTRX00026699	Floral Arr/Holiday Staff Party	Floral Arrangement	17.65
02/28/09	69,661	GLTRX00026987	Variable Allocation - 02/09	Variable Allocation	(16.16)
02/28/09	271,250	PMTRX0000575	E.E.A F/02/09	ANGELA MOORE	7.35
07/15/08	246,048	PMTRX00005160	PTY. CSH. F/07/08	MICHELLE PRESSLEY-PETTY CASH	21.60
07/31/08	247,766	PMTRX00005209	PTY.CSH F/07/08	MICHELLE PRESSLEY-PETTY CASH	8.58
08/21/08	249,966	PMTRX00005273	PTY.CSH. F/08/08	MICHELLE PRESSLEY-PETTY CASH	17.47
09/30/08	255,236	GLTRX00025463	EXP CK#111244 - AMEX 07/08	AMEX	0.69
09/30/08	255,236	GLTRX00025463	EXP CK#111244 - AMEX 07/08	AMEX	2.93
09/30/08	255,236	GLTRX00025463	EXP CK#111244 - AMEX 07/08	AMEX	4.37
09/30/08	255,236	GLTRX00025463	EXP CK#111244 - AMEX 07/08	AMEX	3.83
09/30/08	255,236	GLTRX00025463	EXP CK#111244 - AMEX 07/08	AMEX	4.75
09/30/08	255,705	GLTRX00025467	EXP CK#111244 - AMEX 08/08	AMEX	4.76
09/30/08	255,705	GLTRX00025467	EXP CK#111244 - AMEX 08/08	AMEX	3.74
09/30/08	255,705	GLTRX00025467	EXP CK#111244 - AMEX 08/08	AMEX	5.72
10/31/08	258,486	PMTRX00005490	PTY. CSH. F/11/08	MICHELLE PRESSLEY-PETTY CASH	11.78
11/25/08	260,319	PMTRX00005531	LUNCH FOR IN-SERVICE	PAULETTE STALLWORTH	50.71
12/29/08	69,661	GLTRX00026379	Variable Allocation - 12/08	Variable Allocation	52.06
12/31/08	263,654	GLTRX00026350	EXP CK#112104 - AMEX 09/08	AMEX	4.35
12/31/08	263,654	GLTRX00026350	EXP CK#112104 - AMEX 09/08	AMEX	4.47
12/31/08	265,722	GLTRX00026405	Exp ck107347-Hyatt Regency	Hyatt Regency	2.65
01/29/09	69,661	GLTRX00026686	Variable Allocation - 01/09	Variable Allocation	(0.80)
01/31/09	267,489	PMTRX00005686	PTY.CSH.F/01/09	JOAN ROWE	15.75
01/31/09	268,009	GLTRX00026699	Floral Arr/Holiday Staff Party	Floral Arrangement	1.20
02/28/09	69,661	GLTRX00026987	Variable Allocation - 02/09	Variable Allocation	(1.17)
02/28/09	271,246	PMTRX0000575	E.E.A F/02/09	ALBERT CUELLER III	2.73
03/31/09	274,250	GLTRX00027317	EXP CK#114390 - AMEX 12/08	AMEX	4.71
03/31/09	274,251	GLTRX00027315	EXP CK#115086 - AMEX 01/09	AMEX	3.74
03/31/09	274,251	GLTRX00027315	EXP CK#115086 - AMEX 01/09	AMEX	17.33
03/31/09	274,251	GLTRX00027315	EXP CK#115086 - AMEX 01/09	AMEX	5.23
04/28/09	275,245	PMTRX00005866	PTY. CSH. F/04/09	JOAN ROWE	23.89
04/30/09	276,005	GLTRX00027576	EXP CK#115803 - AMEX 02/09	AMEX	6.90
04/30/09	276,005	GLTRX00027576	EXP CK#115803 - AMEX 02/09	AMEX	12.28
04/30/09	276,005	GLTRX00027576	EXP CK#115803 - AMEX 02/09	AMEX	8.51
04/30/09	277,392	GLTRX00027701	EXP CK#116671 - AMEX 03/09	AMEX	9.30
04/30/09	277,392	GLTRX00027701	EXP CK#116671 - AMEX 03/09	AMEX	4.31
04/30/09	277,392	GLTRX00027701	EXP CK#116671 - AMEX 03/09	AMEX	4.27
04/30/09	277,524	GLTRX00027731	Transfer CILA 8 Expenses to DC	Variable Allocation	8.66
06/30/09	284,683	GLTRX00028513	EXP CK#117521 - AMEX 04/09	AMEX	2.03
06/30/09	284,683	GLTRX00028513	EXP CK#117521 - AMEX 04/09	AMEX	5.79
06/30/09	284,683	GLTRX00028513	EXP CK#117521 - AMEX 04/09	AMEX	3.01
06/30/09	284,683	GLTRX00028513	EXP CK#117521 - AMEX 04/09	AMEX	12.40
06/30/09	284,782	GLTRX00028515	EXP CK#117995 - AMEX 05/09	AMEX	3.61
06/30/09	285,512	GLTRX00028584	EXP CK# 118862 - AMEX 06/09	AMEX	10.17
06/30/09	285,512	GLTRX00028584	EXP CK# 118862 - AMEX 06/09	AMEX	5.35
06/30/09	285,512	GLTRX00028584	EXP CK# 118862 - AMEX 06/09	AMEX	9.91
11/30/08	261,653	PMTRX00005560	E.E.A.F/11/08	NERLENE DOSSOUS	6.67
12/29/08	69,661	GLTRX00026379	Variable Allocation - 12/08	Variable Allocation	52.14
12/31/08	265,722	GLTRX00026405	Exp ck107347-Hyatt Regency	Hyatt Regency	2.66
01/29/09	69,661	GLTRX00026686	Variable Allocation - 01/09	Variable Allocation	(0.79)
01/31/09	267,473	PMTRX00005686	E.E.A.F/01/09	NERLENE DOSSOUS	3.04
01/31/09	268,009	GLTRX00026699	Floral Arr/Holiday Staff Party	Floral Arrangement	1.19
02/28/09	69,661	GLTRX00026987	Variable Allocation - 02/09	Variable Allocation	(1.15)
					$ 1,213.22

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, 2009

HAMMOND HOUSE

DATE	CHECK NO.	Check No.		PAYEE	CONFERENCE NAME	LOCATION	EMPLOYEE	JOB TITLE	DATE OF SEMINAR	SPONSOR	ACCOUNT 3310 15177081 Amount	15178881 Amount	15000031 Amount	Total	Account 3330 Amount	In-State Travel & Seminar
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	AMEX 07/08	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	July 22-24, 2008	SAC		8.81	15.46	24.27		24.27
09/03/08	250,904	111151	HOTEL F/IARF CONFERENCE	EMBASSY SUITES HOTEL	IARF CONFERENCE	East Peoria, IL	Angela Moore	Center Director	October 15-17, 2008	IARF	321.90			321.90		321.90
11/26/08	260,490	113475	ACCT. #00-ASM	I.C.A.N., INC.	IARF CONFERENCE	East Peoria, IL	Angela Moore	Center Director	October 15-17, 2008	IARF	20.00			20.00		20.00
09/30/08	252,177	111151	Corr Ck.111151-Embassy Suites	EMBASSY SUITES HOTEL	IARF CONFERENCE	East Peoria, IL	Paulette Stallworth	Director - Habilitation Services	October 15-17, 2008	IARF	64.38			64.38		64.38
09/03/08	250,904	111151	HOTEL F/IARF CONFERENCE	EMBASSY SUITES HOTEL	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF		18.35	32.19	50.54		50.54
09/03/08	250,905	111165	IARF CONFERENCE	I.C.A.N., INC.	IARF CONFERENCE	East Peoria, IL	Angela Moore	Center Director	October 15-17, 2008	IARF	289.00			289.00		289.00
09/30/08	252,176	111165	Corr cdg Ck.111165 - ICAN	I.C.A.N., INC.	IARF CONFERENCE	East Peoria, IL	Paulette Stallworth	Director - Habilitation Services	October 15-17, 2008	IARF	61.80			61.80		61.80
09/03/08	250,905	111165	IARF CONFERENCE	I.C.A.N., INC.	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF		16.47	28.90	45.37		45.37
06/30/09	287,189	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Jocelyn Peterson	Center Director	October 15-17, 2008	IARF	28.20			28.20		28.20
06/30/09	287,189	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Paulette Stallworth	Director - Habilitation Services	October 15-17, 2008	IARF	5.64			5.64		5.64
06/30/09	287,189	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF		1.61	2.82	4.43		4.43
06/30/09	287,190	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Jocelyn Peterson	Center Director	October 15-17, 2008	IARF	55.03			55.03		55.03
06/30/09	287,190	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Paulette Stallworth	Director - Habilitation Services	October 15-17, 2008	IARF	11.01			11.01		11.01
06/30/09	287,190	112880	EXP AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF		3.14	5.50	8.64		8.64
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	AMEX 10/08	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF		10.76	18.88	29.64		29.64
11/30/08	261,652	113366	E.E.A.F/10/08	ALBERT CUELLER III		Normal, IL	Albert Cueller III	Division Director	November 13, 2008			0.27	0.47	0.74		0.74
01/22/09	265,972	114740	REGISTRATION FEE	ARC OF ILLINOIS	QMRP Leadership	Frankfort, IL	Angela Moore	Center Director	January 27, 2009	ARC OF ILLINOIS	120.00			120.00		120.00
04/20/09	274,569	116886	IL ASSOC SERV COORD CONF HOTEL	HOTEL PERE MARQUETTE	Illinois Assoc. of Service Coordinators Conf.	Peoria, IL	G. Ellis, Pamela Halliburton	Service Coordinator	May 5-8, 2009	Illinois Assoc. of Service Coordinators		143.74		143.74		143.74
04/20/09	274,568	116890	IL ASSOC SERV COORD CONFRENCE	ILLINOIS ASSOCIATION OF SERVICE COORDINATOR	Illinois Assoc. of Service Coordinators Conf.	Peoria, IL	G. Ellis, Pamela Halliburton	Service Coordinator	May 5-8, 2009	Illinois Assoc. of Service Coordinators		72.00		72.00		72.00
04/30/09	275,443	117143	IL ASSOC SERV CORD CONF EX ACC	GWENDOLYN ELLIS	Illinois Assoc. of Service Coordinators Conf.	Peoria, IL	Gwendolyn Ellis	Service Coordinator	May 5-8, 2009	Illinois Assoc. of Service Coordinators		25.95		25.95		25.95
04/30/09	275,444	117147	IL ASSOC SERV CORD CONF EXP AC	PAMELA HALLIBURTON	Illinois Assoc. of Service Coordinators Conf.	Peoria, IL	Pamela Halliburton	Service Coordinator	May 5-8, 2009	Illinois Assoc. of Service Coordinators		28.31		28.31		28.31
05/27/09	278,216	117777	PTY. CSH. F/05/09	JOAN ROWE	In-service	Chicago, IL	Joan Rowe	Secretary II	May 4-6, 2009	Ada S. McKinley Community Services, Inc.			23.00	23.00		23.00
05/27/09	278,226	117792	SEMINAR F/LEGAL & ETHICAL ISSU	BARBARA A. WEINER	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Highland Park, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.		3.71	20.62	24.33		24.33
06/30/09	285,512	118862	EXP CK# 118862 - AMEX 06/09	AMEX 06/09	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Normal, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.		2.75	4.82	7.57		7.57
06/30/09	285,512	118862	EXP CK# 118862 - AMEX 06/09	AMEX 06/09	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Normal, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.		4.60	8.06	12.66		12.66
06/30/09	285,512	118862	EXP CK# 118862 - AMEX 06/09	AMEX 06/09	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Normal, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.		0.55	0.96	1.51		1.51
03/31/09	274,250	114390	EXP CK#114390 - AMEX 12/08	AMEX 12/08									19.80	19.80		19.80
														-		-
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Chesapeake Seafood	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	July 22-24, 2008	SAC				-	4.21	4.21
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Smokey Bones	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	July 22-24, 2008	SAC				-	2.69	2.69
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Mario's Pizza	SAC Conference	Springfield, IL	Albert Cueller III	Division Director	July 22-24, 2008	SAC				-	7.89	7.89
10/31/08	258,533	112949	E.E.A F/10/08	ANGELA MOORE	IARF CONFERENCE	East Peoria, IL	Angela Moore	Center Director	October 15-17, 2008	IARF				-	16.00	16.00
10/31/08	258,518	112910	E.E.A F/10/08	ALBERT CUELLER III	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	3.10	3.10
10/31/08	258,518	112910	E.E.A F/10/08	ALBERT CUELLER III	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	1.77	1.77
11/30/08	262,526	113940	E.E.A.F/11/08	PAULETTE STALLWORTH	IARF CONFERENCE	East Peoria, IL	Paulette Stallworth	Director - Habilitation Services	October 15-17, 2008	IARF				-	3.80	3.80
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Smokey Bones	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	5.96	5.96
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Chesapeake Seafood	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	1.69	1.69
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Blackie's	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	4.87	4.87
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Smokey Bones	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	4.93	4.93
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Monical's Gilman	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	3.61	3.61
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	El Xocomilco	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	1.21	1.21
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Longhorn	IARF CONFERENCE	East Peoria, IL	Albert Cueller III	Division Director	October 15-17, 2008	IARF				-	6.69	6.69
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Grace O'Malley's	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	June 30, 2008	Ada S. McKinley Community Services, Inc.				-	10.65	10.65
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Blackie's	Lunch during housing appointment	Chicago, IL	Albert Cueller III	Division Director	July 7, 2008	Ada S. McKinley Community Services, Inc.				-	6.49	6.49
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Mickey's Casual Dining	Lunch during housing appointment	Chicago, IL	Albert Cueller III	Division Director	July 9, 2008	Ada S. McKinley Community Services, Inc.				-	1.15	1.15
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Chant	Lunch with housing consultant	Chicago, IL	Albert Cueller III	Division Director	July 10, 2008	Ada S. McKinley Community Services, Inc.				-	3.17	3.17
09/30/08	255,236	111244	EXP CK#111244 - AMEX 07/08	Weather Mark Tavern	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	July 21, 2008	Ada S. McKinley Community Services, Inc.				-	9.46	9.46
09/30/08	255,705	111244	EXP CK#111244 - AMEX 08/08	Morgan's	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	August 15, 2008	Ada S. McKinley Community Services, Inc.				-	8.31	8.31
09/30/08	255,705	111244	EXP CK#111244 - AMEX 08/08	La Cantina	Lunch with staff	Chicago, IL	Albert Cueller III	Division Director	August 27, 2008	Ada S. McKinley Community Services, Inc.				-	8.73	8.73
12/31/08	263,654	112104	EXP CK#112104 - AMEX 09/08	La Cantina Grill	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	September 8, 2008	Ada S. McKinley Community Services, Inc.				-	8.68	8.68
12/31/08	263,654	112104	EXP CK#112104 - AMEX 09/08	Olive Garden	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	September 10, 2008	Ada S. McKinley Community Services, Inc.				-	19.91	19.91
12/31/08	263,654	112104	EXP CK#112104 - AMEX 09/08	Bar Louie	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	September 25, 2008	Ada S. McKinley Community Services, Inc.				-	10.09	10.09
12/31/08	263,655	112880	EXP CK#112880 - AMEX 10/08	Cheesecake Factory	Business lunch with 3 HUD staff	Chicago, IL	Albert Cueller III	Division Director	October 14, 2008	Ada S. McKinley Community Services, Inc.				-	16.28	16.28
03/31/09	274,249	113645	EXP CK#113645 - AMEX 11/08	Giordano's	Business lunch	Chicago, IL	Albert Cueller III	Division Director	October 27, 2008	Ada S. McKinley Community Services, Inc.				-	4.10	4.10
03/31/09	274,249	113645	EXP CK#113645 - AMEX 11/08	Tin Fish	Business lunch	Chicago, IL	Albert Cueller III	Division Director	October 28, 2008	Ada S. McKinley Community Services, Inc.				-	7.02	7.02
03/31/09	274,249	113645	EXP CK#113645 - AMEX 11/08	Logan's	Business lunch	Chicago, IL	Albert Cueller III	Division Director	November 13, 2008	Ada S. McKinley Community Services, Inc.				-	4.96	4.96
03/31/09	274,249	113645	EXP CK#113645 - AMEX 11/08	Manny's Coffee Shop	Business lunch	Chicago, IL	Albert Cueller III	Division Director	November 17, 2008	Ada S. McKinley Community Services, Inc.				-	5.04	5.04
03/31/09	274,249	113645	EXP CK#113645 - AMEX 11/08	La Cantina Grill	Business lunch	Chicago, IL	Albert Cueller III	Division Director	November 21, 2008	Ada S. McKinley Community Services, Inc.				-	9.40	9.40
03/31/09	274,250	114390	EXP CK#114390 - AMEX 12/08	La Cantina Grill	Business lunch	Chicago, IL	Albert Cueller III	Division Director	December 9, 2008	Ada S. McKinley Community Services, Inc.				-	7.69	7.69
03/31/09	274,250	114390	EXP CK#114390 - AMEX 12/08	Leona's	Business lunch	Chicago, IL	Albert Cueller III	Division Director	December 17, 2008	Ada S. McKinley Community Services, Inc.				-	15.73	15.73
03/31/09	274,251	115086	EXP CK#115086 - AMEX 01/09	Harvest Table	Travel food	Springfield, IL	Albert Cueller III	Division Director	January 21, 2009	Ada S. McKinley Community Services, Inc.				-	1.80	1.80
03/31/09	274,251	115086	EXP CK#115086 - AMEX 01/09	Smokey Bones Barbecue	Travel food	Springfield, IL	Albert Cueller III	Division Director	January 21, 2009	Ada S. McKinley Community Services, Inc.				-	4.93	4.93
03/31/09	274,251	115086	EXP CK#115086 - AMEX 01/09	Texas Roadhouse	Travel food	Springfield, IL	Albert Cueller III	Division Director	January 22, 2009	Ada S. McKinley Community Services, Inc.				-	5.57	5.57
04/30/09	276,005	115803	EXP CK#115803 - AMEX 02/09	Chi Tung	Business lunch with vendor	Chicago, IL	Albert Cueller III	Division Director	February 13, 2009	Ada S. McKinley Community Services, Inc.				-	4.36	4.36
04/30/09	276,005	115803	EXP CK#115803 - AMEX 02/09	Flaco Taco	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	February 18, 2009	Ada S. McKinley Community Services, Inc.				-	6.59	6.59
04/30/09	276,005	115803	EXP CK#115803 - AMEX 02/09	Flaco Taco	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	February 24, 2009	Ada S. McKinley Community Services, Inc.				-	7.03	7.03
04/30/09	277,392	116671	EXP CK#116671 - AMEX 03/09	M. Lounge	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	March 5, 2009	Ada S. McKinley Community Services, Inc.				-	4.60	4.60
04/30/09	277,392	116671	EXP CK#116671 - AMEX 03/09	Flaco Taco	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	March 26, 2009	Ada S. McKinley Community Services, Inc.				-	8.36	8.36
06/30/09	284,683	117521	EXP CK#117521 - AMEX 04/09	Leona's	Lunch with staff	Chicago, IL	Albert Cueller III	Division Director	April 7, 2009	Ada S. McKinley Community Services, Inc.				-	6.07	6.07
06/30/09	284,683	117521	EXP CK#117521 - AMEX 04/09	The Chew Chew	Meeting with Advocacy Committee	Riverside, IL	Albert Cueller III	Division Director	April 14, 2009	Ada S. McKinley Community Services, Inc.				-	23.70	23.70
06/30/09	284,683	117521	EXP CK#117521 - AMEX 04/09	Lake Pointe Grill	Travel food	Springfield, IL	Albert Cueller III	Division Director	April 15, 2009	Ada S. McKinley Community Services, Inc.				-	11.18	11.18
06/30/09	284,683	117521	EXP CK#117521 - AMEX 04/09	Rusty's Clubhouse	Travel food	Chicago, IL	Albert Cueller III	Division Director	April 16, 2009	Ada S. McKinley Community Services, Inc.				-	10.17	10.17
06/30/09	284,683	117521	EXP CK#117521 - AMEX 04/09	Flaco Taco	Lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	April 22, 2009	Ada S. McKinley Community Services, Inc.				-	6.03	6.03
06/30/09	284,782	117995	EXP CK#117995 - AMEX 05/09	Bar Louie	Lunch with housing consultant	Chicago, IL	Albert Cueller III	Division Director	May 8, 2009	Ada S. McKinley Community Services, Inc.				-	9.20	9.20
06/30/09	284,782	117995	EXP CK#117995 - AMEX 05/09	M Lounge	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	May 22, 2009	Ada S. McKinley Community Services, Inc.				-	3.80	3.80
06/30/09	284,782	117995	EXP CK#117995 - AMEX 05/09	La Cantina	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	May 28, 2009	Ada S. McKinley Community Services, Inc.				-	8.71	8.71
06/30/09	285,512	118862	EXP CK# 118862 - AMEX 06/09	Bar Louie	Business lunch with HUD staff	Chicago, IL	Albert Cueller III	Division Director	June 10, 2009	Ada S. McKinley Community Services, Inc.				-	15.34	15.34
06/30/09	281,309	118648	STAFF LUNCHEON	PAULETTE STALLWORTH	Staff Luncheon	Chicago, IL	Paulette Stallworth	Director - Habilitation Services	June 25, 2009	Ada S. McKinley Community Services, Inc.				-	57.19	57.19
06/30/09	282,849	118887	E.E.A F/06/09	ALBERT CUELLER III	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Normal, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.				-	3.77	3.77
06/30/09	282,849	118887	E.E.A F/06/09	ALBERT CUELLER III	Legal & Ethical Issues in Providing Behavioral Health Svcs.	Normal, IL	Albert Cueller III	Division Director	June 16, 2009	Ada S. McKinley Community Services, Inc.				-	7.49	7.49
	TOTAL HAMMOND HOUSE										**$ 976.96**	**$ 341.02**	**$ 181.48**	**$ 1,499.46**	**$ 431.17**	**$ 1,930.63**

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION
FISCAL YEAR 2009 COST REPORT

DESCRIPTION	HAMMOND
Mileage and auto rental	$ 4,177
Gasoline and vehicle repairs	1,216
Automobile insurance	654
	$ 6,047

ADA S. McKINLEY COMMUNITY SERVICES, INC.
SCHEDULE V - LINE 27 - OTHERS - GENERAL ADMINISTRATION
FISCAL YEAR 2009 COST REPORT

DESCRIPTION	HAMMOND
Other Staff Expenses	$ 186
Client Benefits - Accident Insurance	67
Clothing & Personal Needs	1,565
Miscellaneous	57
	$ 1,875