

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 0036343

Facility Name: Hallmark House Nursing Center

Address: 2501 Allentown Road Pekin 61554
 Number City Zip Code

County: Tazewell

Telephone Number: (309) 347-3121 **Fax #** (309) 347-1547

HFS ID Number: 371262983001

Date of Initial License for Current Owners: 05/01/90

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Rob Schlicht **Telephone Number:** (414) 431-9335

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Rob Schlicht, Manager

(Firm Name & Address) Wipfli, LLP
10000 Innovation Drive, Suite 250

(Telephone) (414) 431-9335 Fax # (414) 431-9303

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,915</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,778</u>	<u>12,991</u>	<u>4,641</u>	<u>22,410</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,778</u>	<u>12,991</u>	<u>4,641</u>	<u>22,410</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.48%

D. How many bed-hold days during this year were paid by the Department? 49 (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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 05/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/20/1980 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 71 and days of care provided 4,641

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	260,029	20,958	12,560	293,547		293,547		293,547		1
2	Food Purchase		167,748		167,748		167,748	(47,669)	120,079		2
3	Housekeeping	151,589	22,752		174,341		174,341		174,341		3
4	Laundry	49,499	14,946		64,445		64,445		64,445		4
5	Heat and Other Utilities			87,041	87,041		87,041	(3,069)	83,972		5
6	Maintenance	54,513	3,075	52,446	110,034		110,034	(7,153)	102,881		6
7	Other (specify):*										7
8	TOTAL General Services	515,630	229,479	152,047	897,156		897,156	(57,891)	839,265		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,289,278	76,919	19,163	1,385,360		1,385,360		1,385,360		10
10a	Therapy	71,517	790	22,065	94,372		94,372		94,372		10a
11	Activities	77,329	4,885	14,329	96,543		96,543	(5,224)	91,319		11
12	Social Services	32,436		1,385	33,821		33,821		33,821		12
13	CNA Training			908	908		908		908		13
14	Program Transportation			2,963	2,963		2,963		2,963		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,470,560	82,594	66,813	1,619,967		1,619,967	(5,224)	1,614,743		16
	C. General Administration										
17	Administrative	83,023		165,000	248,023		248,023	(165,000)	83,023		17
18	Directors Fees										18
19	Professional Services			41,798	41,798	(2,800)	38,998		38,998		19
20	Dues, Fees, Subscriptions & Promotions			48,558	48,558		48,558	(30,677)	17,881		20
21	Clerical & General Office Expenses	112,962	8,178	49,071	170,211		170,211	(12,960)	157,251		21
22	Employee Benefits & Payroll Taxes			333,098	333,098		333,098		333,098		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,485	17,485		17,485	(3,667)	13,818		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			36,343	36,343		36,343		36,343		26
27	Other (specify):*										27
28	TOTAL General Administration	195,985	8,178	691,353	895,516	(2,800)	892,716	(212,304)	680,412		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,182,175	320,251	910,213	3,412,639	(2,800)	3,409,839	(275,419)	3,134,420		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Hallmark House Nursing Center #0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			93,656	93,656		93,656	6,270	99,926		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			15,291	15,291		15,291	24,062	39,353		32
33	Real Estate Taxes			30,299	30,299	2,800	33,099		33,099		33
34	Rent-Facility & Grounds			245,783	245,783		245,783	(244,633)	1,150		34
35	Rent-Equipment & Vehicles			5,077	5,077		5,077		5,077		35
36	Other (specify):*							460	460		36
37	TOTAL Ownership			390,106	390,106	2,800	392,906	(213,841)	179,065		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		136,345	226,961	363,306		363,306		363,306		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			38,873	38,873		38,873		38,873		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		136,345	265,834	402,179		402,179		402,179		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,182,175	456,596	1,566,153	4,204,924		4,204,924	(489,260)	3,715,664		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center# 0036343Report Period Beginning: 01/01/07Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(46,702)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,069)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,848)	30		9
10	Interest and Other Investment Income	(12,258)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(967)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,457)	21		18
19	Entertainment	(3,667)	24		19
20	Contributions	(560)	20		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	(29,268)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(849)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,645)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(359,414)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (359,414)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (462,059)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Hallmark House Nursing Center

ID# 0036343

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Soda Income (Up to the amount of expense)	\$ (3,110)	11	1
2	Avon Income (up to the amount of expense)	(2,114)	11	2
3	Vending Machine Income (up to the amount of exp)	(1,403)	06	3
4	Marketing expense	(4,364)	21	4
5	Bank Charges	(468)	21	5
6	Flowers & Gifts	(995)	21	6
7	Other Misc Income	(4,307)	21	7
8	Loss on sale of assets	(5,750)	06	8
9	PAC dues	(369)	21	9
10	Building Company - Professional Fees	(1,100)	19	10
11	Building Company - Licenses & Permits	(250)	20	11
12	Building Company - Taxes	(2,971)	21	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				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	(27,201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(47,669)	0	0	0	0	0	0	0	0	0	0	(47,669)	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	(3,069)	0	0	0	0	0	0	0	0	0	0	(3,069)	5
6	Maintenance	(7,153)	0	0	0	0	0	0	0	0	0	0	(7,153)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(57,891)	0	0	0	0	0	0	0	0	0	0	(57,891)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,224)	0	0	0	0	0	0	0	0	0	0	(5,224)	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	(5,224)	0	0	0	0	0	0	0	0	0	0	(5,224)	16
	C. General Administration													
17	Administrative	0	0	(165,000)	0	0	0	0	0	0	0	0	(165,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,100)	1,100	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(30,927)	250	0	0	0	0	0	0	0	0	0	(30,677)	20
21	Clerical & General Office Expenses	(15,931)	2,971	0	0	0	0	0	0	0	0	0	(12,960)	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	(3,667)	0	0	0	0	0	0	0	0	0	0	(3,667)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(51,625)	4,321	(165,000)	0	(212,304)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(114,740)	4,321	(165,000)	0	(275,419)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07 Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,848)	9,118	0	0	0	0	0	0	0	0	0	6,270	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,258)	36,320	0	0	0	0	0	0	0	0	0	24,062	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(244,633)	0	0	0	0	0	0	0	0	0	(244,633)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	460	0	0	0	0	0	0	0	0	0	460	36
37	TOTAL Ownership	(15,106)	(198,735)	0	0	0	0	0	0	0	0	0	(213,841)	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)	(129,846)	(194,414)	(165,000)	0	(489,260)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mr. Lloyd Miller	100	None		Advanced Capital	Walnut Creek, CA	Management Co
				Pekin Investment	Pekin, IL	Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 244,633	Pekin Investment Group, LLC	100.00%	\$	\$ (244,633)	1
2	V	19 Professional Fees		Pekin Investment Group, LLC	100.00%	1,100	1,100	2
3	V	32 Interest		Pekin Investment Group, LLC	100.00%	36,320	36,320	3
4	V	21 Taxes		Pekin Investment Group, LLC	100.00%	2,971	2,971	4
5	V	30 Depreciation		Pekin Investment Group, LLC	100.00%	9,118	9,118	5
6	V	36 Amortization		Pekin Investment Group, LLC	100.00%	460	460	6
7	V	20 Licenses & Permits		Pekin Investment Group, LLC	100.00%	250	250	7
8	V	17						8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 244,633			\$ 50,219	\$ * (194,414)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fee	\$ 165,000	Advanced Capital Management	100.00%	\$	\$ (165,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 165,000			\$ 0	\$ * (165,000)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Lloyd Miller	President	Administrative	100.00	None	45	100.00	None	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Advanced Capital Management
 Street Address PO Box 30424
 City / State / Zip Code Walnut Creek, CA 94598
 Phone Number (925) 943-7623
 Fax Number (925) 274-9326

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Living Design		x	Aviary						\$ 735	1									
2	Aadvantage Business		x					85,214		1,067	2									
3	Citi Aadvantage		x					27,160		2,818	3									
4	Citicorp		x					12,330		536	4									
5	See Supplemental Schedule							586,376		42,083	5									
Working Capital																				
6	Busey Bank		x	Line of Credit				75,000		4,372	6									
7											7									
8											8									
9	TOTAL Facility Related							\$ 786,080		\$ 51,611	9									
B. Non-Facility Related*																				
10	Interest Income		x							(371)	10									
11	Dividend Income		x							(10,152)	11									
12	Tax Exempt Dividends		x							(1,735)	12									
13											13									
14	TOTAL Non-Facility Related									\$ (12,258)	14									
15	TOTALS (line 9+line14)							\$ 786,080		\$ 39,353	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Delta Skymiles		x				\$	\$ 16,148			\$ 786	1
2	First National Bank		x	van				22,861			566	2
3	United Visa		x					41,037			1,163	3
4			x					30,846			3,248	4
5	Security Savings Bank	x						475,484			36,320	5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 0	\$ 586,376			\$ 42,083	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14
15	TOTALS (line 9+line14)						\$ 0	\$ 586,376			\$ 42,083	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Cell: P19

Comment: Rob Schlicht:
from related party info

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 29,522	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.)		\$ 29,688	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 166	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 30,133	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.)		\$ 2,800	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.		\$ 33,099	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	28,248	8
	2003	30,827	9
	2004	32,287	10
	2005	28,662	11
	2006	29,522	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<u>Line 5 cost is appraisal cost</u>			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Rob Schlicht

TELEPHONE (414) 431-9335 FAX #: (414) 431-9303

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-10-01-407-018</u>	<u>Long Term Care Property</u>	\$ <u>29,522.00</u>	\$ <u>29,522.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>29,522.00</u>	\$ <u>29,522.00</u>

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 x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Hallmark House Nursing Center

0036343 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,782 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>292,455</u>	<u>1980</u>	<u>\$ 57,000</u>	1
2					2
3	TOTALS	292,455		\$ 57,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1977		41,421		20	1,035	1,035	22,776	9
10	Various		1978		6,473		20			6,473	10
11	Various		1981		10,987		20	275	275	6,046	11
12	Various		1982		12,368		20	309	309	6,801	12
13	Various		1983		7,662		20	191	191	4,207	13
14	Various		1984		2,343		20	58	58	1,280	14
15	Various		1986		17,604		20	482	482	10,296	15
16	Various		1987		7,275		20	228	228	7,275	16
17	Various		1988		42,911		20	2,146	2,146	41,295	17
18	Various		1989		15,387		20	770	770	13,280	18
19	Various		1990		55,198		20	1,464	1,464	24,888	19
20	Various		1991		11,136		20	417	417	9,525	20
21	Various		1993		53,652		20	528	528	19,095	21
22	Various		1994		45,374		20	2,784	2,784	37,584	22
23	Various		1995		110,087		20	4,438	4,438	57,542	23
24	Various		1996		26,910		20	450	450	16,176	24
25	Various		1997		43,197		20	2,250	2,250	30,782	25
26	Various		1998		118,189		20	5,994	5,994	56,944	26
27	Various		1999		29,258		20	897	897	10,307	27
28	Various		2000		253,531		20	9,642	9,642	83,205	28
29	Various		2001		21,498		20	1,312	1,312	9,184	29
30	Various		2002		22,175		20	1,755	1,755	10,530	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		801,016	9,118		20,026	10,908	413,284	67
68								68
69			93,656			(93,656)		69
70		\$ 1,755,652	\$ 102,774		\$ 57,451	\$ (45,323)	\$ 898,775	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,755,652	\$ 102,774		\$ 57,451	\$ (45,323)	\$ 898,775	1
2	Remodel Bathroom	2003	2,237		20	112	112	560	2
3	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	985	3
4	Supressant System	2003	1,368		20	68	68	342	4
5	Griddle Exhaust	2003	2,076		20	104	104	727	5
6	Circuits & Outlets	2003	2,926		20	146	146	731	6
7	Heater in Room 116	2003	1,100		20	55	55	275	7
8	Kitchen Remodel	2003	5,967		20	298	298	1,491	8
9	Blinds	2003	833		20	42	42	209	9
10	Boiler Pump	2003	1,694		20	85	85	396	10
11	Boiler Repari	2003	2,247		20	112	112	487	11
12	Glass Doors	2003	1,602		20	80	80	320	12
13	Boiler	2003	1,154		20	58	58	135	13
14	Lighting	2004	610		20	31	31	123	14
15	Blinds, Valance	2004	8,175		20	409	409	1,871	15
16	Light Fixture	2004	759		20	38	38	152	16
17	Blinds, Valance	2004	9,773		20	489	489	2,189	17
18	Boiler Replacement	2004	4,586		20	229	229	917	18
19	Outside Lighting	2004	3,155		20	158	158	631	19
20	Roof	2004	4,419		20	221	221	884	20
21	Bathroom Remodel	2004	1,054		20	53	53	211	21
22	Cabinets & Countertop	2004	890		20	45	45	179	22
23	Bathroom Flooring	2004	546		20	27	27	109	23
24	Air Conditioner	2004	3,278		20	164	164	656	24
25	Bathroom Remodel	2004	2,000		20	100	100	400	25
26	Cabinets & Countertop	2004	460		20	23	23	92	26
27	Cabinets for Beverage Center	2004	250		20	13	13	51	27
28	Houthous Inc.	2004	7,929		20	396	396	1,585	28
29	Fire Door	2004	879		20	44	44	176	29
30	Hot Water Heater	2004	650		20	33	33	131	30
31	Tub Repairs	2004	539		20	27	27	108	31
32	Tub Repairs	2004	500		20	25	25	33	32
33	Door Locks	2004	985		20	49	49	197	33
34	TOTAL (lines 1 thru 33)		\$ 1,834,235	\$ 102,774		\$ 61,380	\$ (41,394)	\$ 916,126	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,834,235	\$ 102,774		\$ 61,380	\$ (41,394)	\$ 916,126	1
2	Exhaust Fan Repairs	2004	717		20	36	36	144	2
3	Water Heater Repairs	2004	720		20	36	36	144	3
4	Plumbing Repairs	2004	5,620		20	281	281	1,124	4
5	Garbage Disposals	2004	850		20	43	43	171	5
6	Storage Room remodel	2004	696		20	35	35	139	6
7	Room Remodeling	2004	4,496		20	225	225	899	7
8	Back Sidewalk	2005	1,600		20	80	80	240	8
9	Fire Door	2005	487		20	24	24	73	9
10	Front Sidewalk	2005	1,700		20	85	85	255	10
11	Fire Dampers	2005	747		20	37	37	112	11
12	Irrigation System	2005	7,750		20	388	388	1,163	12
13	Landscaping	2005	942		20	47	47	141	13
14	Landscaping	2005	6,028		20	301	301	901	14
15	Fish Pond	2005	5,027		20	251	251	754	15
16	New Office Floor	2005	319		20	16	16	48	16
17	New Walk in cooler floor	2005	800		20	40	40	120	17
18	New Walk in Freezer floor	2005	540		20	27	27	81	18
19	Water system pump	2005	852		20	43	43	128	19
20	Breaker panel replacement	2005	1,952		20	98	98	293	20
21	Public Bathroom Tile	2005	219		20	11	11	33	21
22	Wire Fish pond	2005	1,016		20	51	51	153	22
23	Detectors	2005	860		20	43	43	129	23
24	Gutters	2005	2,375		20	119	119	357	24
25	Mixing Valve	2005	714		20	36	36	107	25
26	Blacktop repair	2005	1,846		20	92	92	276	26
27	Repair blacktop	2005	320		20	16	16	48	27
28	Wire outside lights	2006	1,145		20	57	57	114	28
29	Plywood for Airlock Ceiling	2006	123		20	6	6	12	29
30	Install entry for air lock	2006	3,935		20	197	197	394	30
31	Door for Air lock	2006	3,028		20	151	151	302	31
32	Dining outlet	2006	155		20	8	8	16	32
33	Exhaust Fan & Rewire junction	2006	1,633		20	82	82	164	33
34	TOTAL (lines 1 thru 33)		\$ 1,893,447	\$ 102,774		\$ 64,341	\$ (38,433)	\$ 925,160	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,893,447	\$ 102,774		\$ 64,341	\$ (38,433)	\$ 925,160	1
2	Outlet for Steamer in kitchen	2006	381		20	19	19	38	2
3	Remodel bathroom in room 129	2006	508		20	25	25	50	3
4	Cabinets for bathroom room 129	2006	946		20	47	47	94	4
5	Install floor sink in janitors closet	2006	1,500		20	75	75	150	5
6	New plumbing for bathroom	2006	1,350		20	68	68	136	6
7	Cabinets for bathroom	2006	443		20	22	22	44	7
8	Replace flooring room 129 bathroom	2006	370		20	19	19	38	8
9	New door for nurses station	2006	1,314		20	66	66	132	9
10	Reroof east end	2006	4,928		20	246	246	492	10
11	Flooring for shower room	2006	1,565		20	78	78	156	11
12	Downpayment on ADA Door operator	2006	512		20	26	26	52	12
13	Ada door operator	2006	1,536		20	77	77	154	13
14	New door for activity room	2006	1,710		20	86	86	172	14
15	New carpeting	2006	11,500		20	575	575	1,150	15
16	Tile for bathroom remodel	2006	371		20	19	19	38	16
17	Sidewalk	2006	243		20	12	12	24	17
18	New front sidewalk	2006	757		20	38	38	76	18
19	Flooring for bathroom room 114	2006	465		20	23	23	46	19
20	Cabinets for bathroom	2006	1,168		20	58	58	116	20
21	Finish bathroom remodel room 114	2006	350		20	18	18	36	21
22	New plywood/reroof east end	2006	1,689		20	84	84	168	22
23	New carpeting	2006	11,500		20	575	575	1,150	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	184	24
25	Doors	2007	6,052		20	303	303	303	25
26	Carpeting	2007	11,000		20	550	550	550	26
27	Tile Work	2007	2,930		20	147	147	147	27
28	Hood Systems to alarm	2007	1,836		20	92	92	92	28
29	Electrical work	2007	2,961		20	148	148	148	29
30	Vent air conditioner hall	2007	1,140		20	57	57	57	30
31	Folding Doors	2007	4,236		20	212	212	212	31
32	New AC Dining room	2007	5,800		20	290	290	290	32
33	Bathroom	2007	15,450		20	773	773	773	33
34	TOTAL (lines 1 thru 33)		\$ 1,991,801	\$ 102,774		\$ 69,258	\$ (33,516)	\$ 932,425	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71	1980	1976	\$ 510,430	\$ 9,118	40	\$ 12,761	\$ 3,643	\$ 267,978	4
5										5
6	Adjustments			290,586			7,265	7,265	145,306	6
7										7
8										8
Improvement Type**										9
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										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
SEE ACCOUNTANTS' COMPILATION REPORT

- 1755652 Page 12A
- 32 Page 12B
- 32 Page 12C
- 32 Page 12D
- 0 Page 12E
- 0 Page 12F
- 0 Page 12G
- 0 Page 12H
- 0 Page 12I

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 202,167	\$	\$ 20,217	\$ 20,217	10	\$ 82,948	71
72	Current Year Purchases	53,652		5,365	5,365	10	5,365	72
73	Fully Depreciated Assets	383,790				10	383,790	73
74								74
75	TOTALS	\$ 639,609	\$	\$ 25,582	\$ 25,582		\$ 472,103	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	Facility	1996 Ford Wagon	2007	\$ 35,576	\$	\$	\$	5	\$ 35,576	76
77	Facility	2007 Chevrolet g1500	2007	25,427		5,085	5,085	5	5,085	77
78								5		78
79										79
80	TOTALS			\$ 61,003	\$	\$ 5,085	\$ 5,085		\$ 40,661	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)	\$ 2,749,413	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,926	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,848)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,445,189	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	2007 Chevrolet HHR (2007)	\$ 18,012	\$ 901	\$ 901	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 18,012	\$ 901	\$ 901	91

G. Construction-in-Progress

	Description	Cost	
92			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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage Rental				1,150			5
6								6
7	TOTAL				\$ 1,150			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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 Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		908		908
9	TOTALS	\$	\$ 908	\$	\$ 908
10	SUM OF line 9, col. 1 and 2 (e)	\$	908		

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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	\$		\$ 81,864	\$		\$ 81,864	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			17,812			17,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			108,938			108,938	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				136,345		136,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 208,614	\$ 136,345		\$ 344,959	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center# 0036343Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(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	\$ 350,095	\$ 350,095	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	594,349	594,349	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,667	9,667	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,226	10,226	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 964,337	\$ 964,337	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		111,500	13
14	Buildings, at Historical Cost		1,098,944	14
15	Leasehold Improvements, at Historical Cost	722,863	722,863	15
16	Equipment, at Historical Cost	718,624	830,124	16
17	Accumulated Depreciation (book methods)	(1,036,147)	(2,081,459)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 405,340	\$ 681,972	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,369,677	\$ 1,646,309	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,263	\$ 184,263	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,839	150,839	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,744	3,744	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,133	30,133	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 368,979	\$ 368,979	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	312,914	788,398	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 312,914	\$ 788,398	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 681,893	\$ 1,157,377	46
47	TOTAL EQUITY(page 18, line 24)	\$ 687,784	\$ 488,932	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,369,677	\$ 1,646,309	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 769,419	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 769,419	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(80,396)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>FMV change in stocks</u>	(1,239)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (81,635)	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)	\$ 687,784	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center# 0036343Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,058,201	1
2	Discounts and Allowances for all Levels	(45,075)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,013,126	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	707	13
14	Non-Patient Meals	46,702	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	26,116	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 73,525	23
D. Non-Operating Revenue			
24	Contributions	1,162	24
25	Interest and Other Investment Income***	12,258	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,420	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	24,457	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,457	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,124,528	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	897,156	31
32	Health Care	1,619,967	32
33	General Administration	895,516	33
B. Capital Expense			
34	Ownership	390,106	34
C. Ancillary Expense			
35	Special Cost Centers	363,306	35
36	Provider Participation Fee	38,873	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,204,924	40
41	Income before Income Taxes (line 30 minus line 40)**	(80,396)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (80,396)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Center

0036343

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	2,024	2,112	\$ 58,832	\$ 27.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,025	14,582	323,002	22.15	3
4	Licensed Practical Nurses	13,499	14,351	278,050	19.37	4
5	CNAs & Orderlies	51,720	53,971	601,955	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,839	6,095	71,518	11.73	8
9	Activity Director	2,008	2,088	32,989	15.80	9
10	Activity Assistants	4,266	4,528	44,340	9.79	10
11	Social Service Workers	2,008	2,096	32,436	15.48	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,089	43,363	20.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,276	19,169	216,667	11.30	15
16	Dishwashers					16
17	Maintenance Workers	3,037	3,261	54,513	16.72	17
18	Housekeepers	11,002	11,555	151,589	13.12	18
19	Laundry	5,223	5,605	49,499	8.83	19
20	Administrator	2,016	2,089	83,023	39.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,968	2,089	33,898	16.23	23
24	Clerical	4,004	4,177	79,064	18.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,944	2,088	27,437	13.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,891	151,945	\$ 2,182,175 *	\$ 14.36	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	111	\$ 420	01-03	35
36	Medical Director	monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,443	10-03	39
40	Physical Therapy Consultant	194	12,405	10a-03	40
41	Occupational Therapy Consultant	147	8,250	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,410	10a-03	43
44	Activity Consultant	25	1,375	11-03	44
45	Social Service Consultant	25	1,375	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	527	\$ 34,678		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	303	5,385	10-03	52
53	TOTAL (lines 50 - 52)	303	\$ 5,385		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hallmark House Nursing Center

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	n/a		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? Yes
If YES, give association name and amount. IHCA - \$3919
- (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? _____
- (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? _____
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,320 Line 10
- (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. _____
- (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. \$ 38,873
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? Yes
- (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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 46,702
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? No
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? Yes
g. Does the facility transport residents to and from day training? No
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? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT