



Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343 Report Period Beginning: 1/1/13 Ending: 12/31/13

**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	71	Skilled (SNF)	71	25,915	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	71	TOTALS	71	25,915	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,769	8,360	6,487	21,616	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,769	8,360	6,487	21,616	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 83.41%

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

563 (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)**

**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 12/20/80

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date 12/20/80 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 6,487

Medicare Intermediary NGS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/13 Ending: 12/31/13

**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
	<b>A. General Services</b>										
1	Dietary	157,206	12,503	11,789	181,498		181,498		181,498		1
2	Food Purchase		170,688		170,688		170,688	(71)	170,617		2
3	Housekeeping	114,962	23,143	3,404	141,509	(1,538)	139,971		139,971		3
4	Laundry	34,560	5,215	1,510	41,285	(1,456)	39,829		39,829		4
5	Heat and Other Utilities			81,472	81,472	467	81,939		81,939		5
6	Maintenance	44,550	15,665	127,506	187,721		187,721		187,721		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	351,278	227,214	225,681	804,173	(2,527)	801,646	(71)	801,575		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,750	21,750		21,750		21,750		9
10	Nursing and Medical Records	1,582,903	153,032	63,891	1,799,826	(14,448)	1,785,378	(495)	1,784,883		10
10a	Therapy	30,672	947	519,468	551,087		551,087		551,087		10a
11	Activities	66,443	1,776	12,896	81,115		81,115		81,115		11
12	Social Services	37,176		1,368	38,544		38,544		38,544		12
13	CNA Training										13
14	Program Transportation			2,574	2,574		2,574		2,574		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,717,194	155,755	621,947	2,494,896	(14,448)	2,480,448	(495)	2,479,953		16
	<b>C. General Administration</b>										
17	Administrative	86,408			86,408		86,408		86,408		17
18	Directors Fees										18
19	Professional Services			32,113	32,113	1,103	33,216	1,250	34,466		19
20	Dues, Fees, Subscriptions & Promotions			30,168	30,168	(12,570)	17,598	(829)	16,769		20
21	Clerical & General Office Expenses	83,262	10,826	108,914	203,002	(1,703)	201,299	(44,672)	156,627		21
22	Employee Benefits & Payroll Taxes			392,357	392,357	25,654	418,011		418,011		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,938	3,938		3,938		3,938		24
25	Other Admin. Staff Transportation			5,845	5,845		5,845	(3,063)	2,782		25
26	Insurance-Prop.Liab.Malpractice			45,566	45,566	4,491	50,057	(903)	49,154		26
27	Other (specify):* <b>Bad debt</b>			8,352	8,352		8,352	(8,352)			27
28	<b>TOTAL General Administration</b>	169,670	10,826	627,253	807,749	16,975	824,724	(56,569)	768,155		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,238,142	393,795	1,474,881	4,106,818		4,106,818	(57,135)	4,049,683		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 &amp; ID Number

Hallmark House Nursing Ctr

#0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			48,453	48,453		48,453	54,907	103,360			30
31	Amortization of Pre-Op. & Org.							460	460			31
32	Interest			6,654	6,654		6,654	41,006	47,660			32
33	Real Estate Taxes			32,944	32,944		32,944		32,944			33
34	Rent-Facility & Grounds			269,695	269,695		269,695	(269,695)				34
35	Rent-Equipment & Vehicles			6,415	6,415		6,415		6,415			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			364,161	364,161		364,161	(173,322)	190,839			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		245,279	12,215	257,494		257,494		257,494			39
40	Barber and Beauty Shops	25,979		627	26,606		26,606		26,606			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,805	189,805		189,805		189,805			42
43	Other (specify):* <b>State Tax</b>			7,178	7,178		7,178		7,178			43
44	<b>TOTAL Special Cost Centers</b>	25,979	245,279	209,825	481,083		481,083		481,083			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,264,121	639,074	2,048,867	4,952,062		4,952,062	(230,457)	4,721,605			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 Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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				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				9
10	Interest and Other Investment Income	(482)	32		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)				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	(8,352)	27		24
25	Fund Raising, Advertising and Promotional	(829)	20		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 See page 5A	(7,058)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (16,721)		\$	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)	(213,736)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (213,736)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (230,457)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Hallmark House Nursing Ctr

ID# 0036343

Report Period Beginning: 1/1/13

Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Capitalization of computer systems	\$ (40,711)	21	1
2	Adjustments to offset refunds and rebates	(3,961)	21	2
3	against related costs:	(903)	26	3
4	See above note	(71)	2	4
5	See above note	(495)	10	5
6	Depreciation Adjustment	42,146	30	6
7	Out of state travel	(3,063)	25	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				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	<b>Total</b>	(7,058)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(71)	0	0	0	0	0	0	0	0	0	0	(71)	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	<b>TOTAL General Services</b>	<b>(71)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(71)</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(495)	0	0	0	0	0	0	0	0	0	0	(495)	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	<b>TOTAL Health Care and Programs</b>	<b>(495)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(495)</b>	<b>16</b>
<b>C. General Administration</b>														
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	1,250	0	0	0	0	0	0	0	0	0	1,250	19
20	Fees, Subscriptions & Promotions	(829)	0	0	0	0	0	0	0	0	0	0	(829)	20
21	Clerical & General Office Expenses	(44,672)	0	0	0	0	0	0	0	0	0	0	(44,672)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,063)	0	0	0	0	0	0	0	0	0	0	(3,063)	25
26	Insurance-Prop.Liab.Malpractice	(903)	0	0	0	0	0	0	0	0	0	0	(903)	26
27	Other (specify):*	(8,352)	0	0	0	0	0	0	0	0	0	0	(8,352)	27
28	<b>TOTAL General Administration</b>	<b>(57,819)</b>	<b>1,250</b>	<b>0</b>	<b>(56,569)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(58,385)</b>	<b>1,250</b>	<b>0</b>	<b>(57,135)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

## 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	42,146	12,761	0	0	0	0	0	0	0	0	0	54,907	30
31	Amortization of Pre-Op. & Org.	0	460	0	0	0	0	0	0	0	0	0	460	31
32	Interest	(482)	41,488	0	0	0	0	0	0	0	0	0	41,006	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(269,695)	0	0	0	0	0	0	0	0	0	(269,695)	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	<b>TOTAL Ownership</b>	<b>41,664</b>	<b>(214,986)</b>	<b>0</b>	<b>(173,322)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(16,721)</b>	<b>(213,736)</b>	<b>0</b>	<b>(230,457)</b>	<b>45</b>								

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Diane Miller	100%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 269,695	Pekin Investment Group, LLC		\$	(269,695)	1
2	V	19 Professional Fees		Pekin Investment Group, LLC		1,250	1,250	2
3	V	32 Interest		Pekin Investment Group, LLC		41,488	41,488	3
4	V	30 Depreciation		Pekin Investment Group, LLC		12,761	12,761	4
5	V	31 Amortization		Pekin Investment Group, LLC		460	460	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		\$ 269,695			\$ 55,959	\$ * (213,736)	14

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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	<b>Total</b>		\$			\$	0	\$ *

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

Facility Name & ID Number

Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	None								\$ 0	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	\$ 0	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 Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending: 12/31/13

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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	NA	NA			\$ 0	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1		x	Mortgage			\$	\$		\$ 41,488	1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6		x	Line of credit				257,496		6,654	6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$ 257,496		\$ 48,142	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 257,496		\$ 48,142	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.			\$ <b>31,455</b>	<b>1</b>	
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.)			\$ <b>34,110</b>	<b>2</b>	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>2,655</b>	<b>3</b>	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>30,289</b>	<b>4</b>	
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>5</b>	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>6</b>	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>32,944</b>	<b>7</b>	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	<b>2008</b>	<b>31,953</b>	<b>8</b>		
	<b>2009</b>	<b>32,838</b>	<b>9</b>		
	<b>2010</b>	<b>33,903</b>	<b>10</b>		
	<b>2011</b>	<b>31,490</b>	<b>11</b>		
	<b>2012</b>	<b>34,110</b>	<b>12</b>		
				<b>FOR BHF USE ONLY</b>	
				<b>13</b>	<b>13</b>
				<b>14</b>	<b>14</b>
				<b>15</b>	<b>15</b>
				<b>16</b>	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

**2012 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hallmark House Nursing Ctr COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Margel S. Peddicord, CPA

TELEPHONE 618-315-6242 FAX #: ( )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-10-01-407-018</u>	<u>LTC Facility</u>	\$ <u>34,110.08</u>	\$ <u>34,110.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>34,110.08</u></u>	\$ <u><u>34,110.08</u></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 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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).

NA

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>LTC facility</u>	<u>292,455</u>	<u>1980</u>	<u>\$ 57,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>292,455</b>		<b>\$ 57,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71	1980	1976	\$ 510,430	\$ 12,988	40	\$ 12,761	\$ (227)	\$ 344,544	4
5										5
6		1980	1976	290,586	32,796	40	7,265	(25,531)	188,896	6
7										7
8										8
<b>Improvement Type**</b>										
9	Building Improvements		1977	41,421		20	1,035	1,035	28,986	9
10	Building Improvements		1978	6,473		20			6,473	10
11	Building Improvements		1981	10,987		20	275	275	7,696	11
12	Building Improvements		1982	12,368		20	309	309	8,655	12
13	Building Improvements		1983	7,662		20	191	191	5,353	13
14	Building Improvements		1984	2,343		20	58	58	1,628	14
15	Building Improvements		1986	17,604		20	482	482	13,188	15
16	Building Improvements		1987	7,275		20			7,275	16
17	Building Improvements		1988	42,911		20			42,911	17
18	Building Improvements		1989	15,387		20	(203)	(203)	15,184	18
19	Building Improvements		1990	55,198		20	1,464	1,464	33,672	19
20	Building Improvements		1991	11,136		20	360	360	11,496	20
21	Building Improvements		1993	53,652		20	528	528	22,263	21
22	Building Improvements		1994	45,374		20	(562)	(562)	44,812	22
23	Building Improvements		1995	110,087		20	4,438	4,438	84,170	23
24	Building Improvements		1996	26,910		20	450	450	18,876	24
25	Building Improvements		1997	43,197		20	2,250	2,250	44,282	25
26	Building Improvements		1998	118,189		20	5,994	5,994	92,908	26
27	Building Improvements		1999	29,258		20	897	897	23,789	27
28	Building Improvements		2000	253,531		20	9,642	9,642	141,057	28
29	Building Improvements		2001	21,498		20	1,312	1,312	17,056	29
30	Building Improvements		2002	22,175		20	1,755	1,755	21,060	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 &amp; ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodel bathroom	2003	\$ 2,237	\$	20	\$ 112	\$ 112	\$ 1,232	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	2,167	38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20	68	68	751	39
40	Griddle Exhaust	2003	2,076		20	104	104	1,351	40
41	Circuits & Outlets	2003	2,926		20	146	146	1,608	41
42	Heater in room 116	2003	1,100		20	55	55	605	42
43	Kitchen Remodel	2003	5,967		20	298	298	3,280	43
44	Blinds	2003	833		20	42	42	460	44
45	Boiler Pump	2003	1,694		20	85	85	905	45
46	Boiler Repair	2003	2,247		20	112	112	1,160	46
47	Glass Doors	2003	1,602		20	80	80	800	47
48	Boiler	2003	1,154		20	58	58	482	48
49	Lighting	2004	610		20	31	31	308	49
50	Blinds, Valance	2004	8,175		20	409	409	4,325	50
51	Light Fixture	2004	759		20	38	38	380	51
52	Blinds & vallance	2004	9,773		20	489	489	5,122	52
53	Boiler	2004	4,586		20	229	229	2,292	53
54	Outside lighting	2004	3,155		20	158	158	1,579	54
55	Roof	2004	4,419		20	221	221	2,210	55
56	Bathroom remodel	2004	1,054		20	53	53	528	56
57	Cabinets & countertop	2004	890		20	45	45	448	57
58	Bathroom flooring	2004	546		20	27	27	272	58
59	Air conditioner	2004	3,278		20	164	164	1,640	59
60	Bathroom remodel	2004	2,000		20	100	100	1,000	60
61	Cabinets & countertop	2004	460		20	23	23	230	61
62	Cabinets in beverage centger	2004	250		20	13	13	128	62
63	Houthous	2004	7,929		20	396	396	3,962	63
64	Fire Door	2004	879		20	44	44	440	64
65	Hot water heater	2004	650		20	33	33	328	65
66	Tub repairs	2004	539		20	27	27	270	66
67	Tub repairs	2004	500		20	25	25	183	67
68	Door locks	2004	985		20	49	49	492	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,834,235	\$ 45,784		\$ 54,632	\$ 8,848	\$ 1,267,168	70

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

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,834,235	\$ 45,784		\$ 54,632	\$ 8,848	\$ 1,267,168	1
2	Exhaust fan repairs	2004	717		20	36	36	360	2
3	Water heater repairs	2004	720		20	36	36	360	3
4	Plumbing repairs	2004	5,620		20	281	281	2,810	4
5	Garbage Disposals	2004	850		20	43	43	428	5
6	Storage room remodel	2004	696		20	35	35	349	6
7	Room Remodel	2004	4,496		20	225	225	2,249	7
8	Back sidewalk	2005	1,600		20	80	80	720	8
9	Fire door	2005	487		20	24	24	218	9
10	Front sidewalk	2005	1,700		20	85	85	765	10
11	Fire Dampers.	2005	747		20	37	37	335	11
12	Irrigation System	2005	7,750		20	388	388	3,490	12
13	Landscaping	2005	942		20	47	47	423	13
14	Landscaping	2005	6,028		20	301	301	2,708	14
15	Fish pond	2005	5,027		20	251	251	2,261	15
16	Office floor	2005	319		20	16	16	144	16
17	Walk in cooler floor	2005	800		20	40	40	360	17
18	Walk in freezer floor	2005	540		20	27	27	296	18
19	Water system pump	2005	852		20	43	43	385	19
20	Breaker panel replacement	2005	1,952		20	98	98	880	20
21	Public bath tile	2005	219		20	11	11	99	21
22	Wire fish pond	2005	1,016		20	51	51	459	22
23	Detectors	2005	860		20	43	43	387	23
24	Gutters	2005	2,375		20	119	119	1,071	24
25	Mixing valve	2005	714		20	36	36	322	25
26	Blacktop repair	2005	1,846		20	92	92	829	26
27	Blacktop repair	2005	320		20	16	16	144	27
28	Wire outside lights	2006	1,145		20	57	57	457	28
29	Plywood for Air lock ceiling	2006	123		20	6	6	48	29
30	Install entry for air lock	2006	3,935		20	197	197	1,576	30
31	Door for air lock	2006	3,028		20	151	151	1,209	31
32	Dining outlet	2006	155		20	8	8	64	32
33	Exhaust fan & rewire junction	2006	1,633		20	82	82	655	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,893,447	\$ 45,784		\$ 57,594	\$ 11,810	\$ 1,294,029	34

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

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,893,447	\$ 45,784		\$ 57,594	\$ 11,810	\$ 1,294,029	1
2	Outlet for steamer in kitchen	2006	381		20	19	19	152	2
3	Remodeol bathroom 129	2006	508		20	25	25	201	3
4	Cabinets for bath in Rm 129	2006	946		20	47	47	377	4
5	Install sink in janitor closet	2006	1,500		20	75	75	600	5
6	Plumbing for bathroom	2006	1,350		20	68	68	543	6
7	Cabinets for bath	2006	443		20	22	22	176	7
8	Replace flooring in rm 129 bath	2006	370		20	19	19	151	8
9	New door nurses station	2006	1,314		20	66	66	527	9
10	Reroof east end	2006	4,928		20	246	246	1,969	10
11	Flooring shower room	2006	1,565		20	78	78	625	11
12	Ada door opener downpay	2006	512		20	26	26	207	12
13	Ada door opener	2006	1,536		20	77	77	616	13
14	New activity room door	2006	1,710		20	86	86	687	14
15	New carpeting	2006	11,500		20	575	575	4,600	15
16	Tile bathroom remodel	2006	371		20	19	19	151	16
17	Sidewalk	2006	243		20	12	12	96	17
18	Sidewalk in front	2006	757		20	38	38	304	18
19	Bathroom flooring Rm 114	2006	465		20	23	23	185	19
20	Cabinets for bathroom	2006	1,168		20	58	58	465	20
21	Bathroom remoded rm 114	2006	350		20	18	18	143	21
22	Plywood reroof east end	2006	1,689		20	84	84	673	22
23	Carpeting	2006	11,500		20	575	575	4,600	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	736	24
25	Doors	2007	6,052		20	303	303	2,120	25
26	Carpeting	2007	11,000		20	550	550	3,850	26
27	Tile work	2007	2,930		20	147	147	1,028	27
28	Hood systems to alarm	2007	1,836		20	92	92	644	28
29	Electrical work	2007	2,961		20	148	148	1,036	29
30	Vent air conditioner hall	2007	1,140		20	57	57	399	30
31	Folding doors	2007	4,236		20	212	212	1,484	31
32	AC Dining room	2007	5,800		20	290	290	2,030	32
33	Bathroom	2007	15,450		20	773	773	5,410	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,991,801	\$ 45,784		\$ 62,514	\$ 16,730	\$ 1,330,814	34

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

Facility Name &amp; ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,991,801	\$ 45,784		\$ 62,514	\$ 16,730	\$ 1,330,814	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20	1,486	1,486	8,916	2
3	Plumbing return line	2008	2,875		20	144	144	864	3
4	Boiler	2008	5,631		20	282	282	1,692	4
5	AC basement office	2008	452		20	23	23	138	5
6	SPA tile	2008	3,530		20	177	177	1,062	6
7	Walk in	2008	29,462		20	1,473	1,473	8,838	7
8	Heat pkg dining room	2008	301		20	15	15	90	8
9	Install fans in kitchen	2008	1,650		20	83	83	498	9
10	Install grease trap	2008	1,894		20	95	95	570	10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20	436	436	2,180	11
12	Lighting	2010	12,987		40	325	325	1,002	12
13	Generator	2010	48,199		10	4820	4,820	16,468	13
14	Kitchen air conditioner	2011	14,198		40	355	355	947	14
15	Heating unit	2011	3,783		40	95	95	229	15
16	Tankless water heaters (2)	2011	6,500		10	650	650	1,517	16
17	Roof over dining room	2011	17,885		40	447	447	1,304	17
18	Doors for Gazebo entrance	2011	5,018		40	125	125	355	18
19	Hallway lighting	2011	3,575		40	89	89	245	19
20	Therapy door	2011	4,470		40	112	112	299	20
21	Expansion joints repair	2011	2,806		40	70	70	163	21
22	Roof on Admin . Bldg.	2012	15,456		20	1,546	1,546	3,092	22
23	Sidewalks in front of facility	2012	8,850		20	885	885	1,770	23
24	Boiler	2012	16,885		20	1,689	1,689	3,378	24
25	Parking lot expansion	2013	49,995		20	1,250	1,250	1,250	25
26	Dining room remodel-sink, ceiling tiles, cabinets, counter top, floor	2013	5,689		40	71	71	71	26
27	Fire system upgrade	2013	6,347		10	317	317	317	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,298,684	\$ 45,784		\$ 79,574	\$ 33,790	\$ 1,388,069	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 172,634	\$ 10,586	\$ 18,049	\$ 7,463	var.	\$ 94,836	71
72	Current Year Purchases	114,736	4,844	5,737	893	10	5,736	72
73	Fully Depreciated Assets	582,461					582,461	73
74								74
75	TOTALS	\$ 869,831	\$ 15,430	\$ 23,786	\$ 8,356		\$ 683,033	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Ford Van	1996	\$ 35,576	\$	\$	\$		\$ 35,576	76
77	Facility	2007 Chevy HHR	2007	18,012					18,012	77
78										78
79										79
80	TOTALS			\$ 53,588	\$	\$	\$		\$ 53,588	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)	\$ 3,279,103	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,214	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,360	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 42,146	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,124,690	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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								5
6								6
7	<b>TOTAL</b>				\$ _____			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  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: \$ 6,415 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	<b>TOTAL</b>		\$ _____	\$ _____	21

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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-3	1499	hrs	\$ 196,799		\$	\$	1,499	\$ 196,799	1
2	Licensed Speech and Language Development Therapist	10a-3	314	hrs	59,642				314	59,642	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-3	1631	hrs	212,998				1,631	212,998	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	<b>TOTAL</b>				\$ 469,439		\$	\$	3,444	\$ 469,439	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.

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 424,982	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,198,793		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	212,840		5
6	Prepaid Insurance	7,439		6
7	Other Prepaid Expenses	3,483		7
8	Accounts Receivable (owners or related parties)	132,589		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,980,126	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	940,831		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,005,538		16
17	Accumulated Depreciation (book methods)	(1,365,504)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 580,865	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,560,991	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 129,766	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	257,496		29
30	Accrued Salaries Payable	71,314		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,057		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,187		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Assessment Tax Due to HFS	140,900		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 634,720	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 634,720	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,926,271	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,560,991	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,687,427</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Correction</b>	<b>4,613</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,692,040</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>234,231</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>234,231</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,926,271</b>	<b>24</b> *

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

Facility Name &amp; ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning: 1/1/13

Ending: 12/31/13

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,191,206	1
2	Discounts and Allowances for all Levels	(78,663)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,112,543	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	16,744	13
14	Non-Patient Meals	15,532	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 32,276	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	5	24
25	Interest and Other Investment Income***	482	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 487	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Attachment #1</u>	40,665	28
28a	<u>Vending revenue in excess of vending expense</u>	322	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 40,987	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,186,293	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	804,173	31
32	Health Care	2,521,612	32
33	General Administration	781,033	33
<b>B. Capital Expense</b>			
34	Ownership	364,161	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	291,278	35
36	Provider Participation Fee	189,805	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,952,062	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	234,231	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 234,231	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 953,284	44
45	Private Pay - Net Inpatient Revenue	2,669,189	45
46	Medicare - Net Inpatient Revenue	1,568,733	46
47	Other-(specify) <u>Discounts</u>	(78,663)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,112,543	49

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

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

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

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

Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13

**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	1,920	1,992	\$ 73,412	\$ 36.85	1
2	Assistant Director of Nursing	1,657	1,673	47,146	28.18	2
3	Registered Nurses	12,077	12,620	331,642	26.28	3
4	Licensed Practical Nurses	13,102	13,692	296,106	21.63	4
5	CNAs & Orderlies	62,642	64,563	661,869	10.25	5
6	CNA Trainees	17	17	157	9.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,996	2,082	27,879	13.39	9
10	Activity Assistants	3,626	3,760	38,136	10.14	10
11	Social Service Workers	1,854	1,891	36,868	19.50	11
12	Dietician					12
13	Food Service Supervisor	1,906	1,984	50,769	25.59	13
14	Head Cook	6,114	6,368	61,043	9.59	14
15	Cook Helpers/Assistants	5,362	5,571	48,647	8.73	15
16	Dishwashers					16
17	Maintenance Workers	3,399	3,536	44,281	12.52	17
18	Housekeepers	9,535	9,763	88,067	9.02	18
19	Laundry	3,751	3,847	35,859	9.32	19
20	Administrator	2,000	2,080	86,408	41.54	20
21	Assistant Administrator					21
22	Other Administrative	2,998	3,119	46,029	14.76	22
23	Office Manager	1,932	2,015	36,913	18.32	23
24	Clerical					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	1,918	1,984	36,559	18.43	31
32	Other Health Care(specify)	8,536	8,802	149,183	16.95	32
33	Other(specify) <u>Cosmetologist</u>	1,530	1,589	25,684	16.16	33
34	TOTAL (lines 1 - 33)	147,872	152,948	\$ 2,222,657 *	\$ 14.53	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	124	\$ 5,527	1-3	35
36	Medical Director		21,750	9-3	36
37	Medical Records Consultant		1,960	10-3	37
38	Nurse Consultant		473	10-3	38
39	Pharmacist Consultant		5,367	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,885	11-3	44
45	Social Service Consultant		1,885	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	124	\$ 38,847		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$	50
51	Licensed Practical Nurses	0		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	0	\$	53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lynn Brady	Administrator	0	\$ 8,797	Workers' Compensation Insurance	\$ 88,399	IDPH License Fee	\$	
Laurie Warren	Interim Admin.	0	23,480	Unemployment Compensation Insurance		Advertising: Employee Recruitment	9,916	
Ben Perkins	Administrator	0	54,131	FICA Taxes	244,408	Health Care Worker Background Check	2,340	
				Employee Health Insurance	55,245	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	2,613	
				Retirement plan	24,076	Misc. See Attachment #1	1,900	
				Employee physicals	4,777	Marketing \$269 + \$559	828	
				Uniforms and other	1,106			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 86,408					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Margel S.Peddicord, CPA	Medicaid CR & Capital		\$ 3,442			\$	Out-of-State Travel	\$
McGladrey	Accounting		17,975					
Hawkes & Hastings	Accounting		1,250					
Plante & Moran	Medicare CR		2,300				In-State Travel	
Legal Shield	Legal		6,067					
Michael T. Mahoney, LTD	Legal		1,080					
Elias, Meginned, Riffle	Legal		1,102				Seminar Expense	3,938
							See attachment	
TOTAL (agree to Schedule V, line 19, column 3)							Entertainment Expense	( )
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 33,216				(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 3,938

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	NA			\$	\$	\$	\$	\$	\$	\$	\$	\$												
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	<b>TOTALS</b>			\$	\$	\$	\$	\$	\$	\$	\$	\$												

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

1/1/13

Ending:

12/31/13**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. Illinois Health Care Association \$2,613
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,026 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. NA
- (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. \$ 189,805  
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? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? See Adjustment  
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? \_\_\_\_\_  
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? 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: \_\_\_\_\_
- (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

**Page 20, Line 32, Other Health Care**

Staff Type	Hours Worked	Hours Paid	Total Paid
Clinic Compliance Coordinator	572	627	\$ 18,182
MDS Coordinator	4,640	4,787	\$ 55,017
Nursing Admin. Asst.	2,212	2,252	\$ 45,312
Therapy Director	1,112	1,136	\$ 30,672
Totals	<u>8,536</u>	<u>8,802</u>	<u>\$ 149,183</u>

**Page 21, Section F**

Subscriptions	\$ 345
MES/HPSI	175
IL Fire Marshal	70
IL Secretary of State	711
Citi Visa	10
National Notary Association	89
Pekin Area Chamber	500
Total	<u>\$ 1,900</u>

**Page 19, Line 28**

Income Tax refunds State and Federal	\$ 20,025
Rebates and refunds See adjustments to cost on Schedule V	5,431
Insurance proceeds in excess of cost to repair	6,701
Miscellaneous income	8,508
Total on Page 19, Line 28	<u>\$ 40,665</u>

**Page 3, line 25**

Other Administrative Transportation Fuel and related costs for vehicles and related mileage costs	<u>\$ 2,782</u>
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**Hallmark House  
Support Schedules - Travel and Seminar  
For the Year Ended December 31, 2013**

Month of Service	Name of Individuals Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Classification	Cost
13-Apr	Deb Bohanan	MDS Coordinator		Peoria, IL		Illinois Health Care	2,5	\$90.00
10-May	Amy Willaims	Activity Director		Champaign, IL	Activity Director Class Course	Health Services Consultant	2,5	\$355.50
10-May	Deb Bohanan	MDS Coordinator		West Des Moines, IA		Leading Age Iowa	1,4	\$210.00
Aug	Susan Sullivan	Admin. Assist.		Jackson, MI	Software Training and information	American Healthtech	1,4	\$970.04
Aug	Deb Bohanan	MDS Coordinator		Jackson, MI	Software Training and information	American Healthtech	1,4	\$970.04
7-Aug	Deb Bohanan	MDS Coordinator		Bettendorf, IA	Medicare Therapy	Summit Professional Education	1,4	\$169.00
7-Aug	Kessy Thompson	Therapy Director		Bettendorf, IA	Medicare Therapy	Summit Professional Education	1,4	\$169.00
30-Sep	Deb Bohanan	MDS Coordinator				AANAC		\$209.00
10-Oct	Ben Perkins	Administrator		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Randi Leinheart	Social Service		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Deb Bohanan	MDS Coordinator		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Susan Sullivan	Admin. Assist.		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Jenny Cooper	Office Manager		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Laurie Warren	DON		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Cheryl Carlson	ADON		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Kessy Thompson	Therapy Director		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.33
10-Oct	Emily Marshall	C.N.A. Supervisor		Peoria, IL	63rd Convention	Illinois Health Care	2,5	\$88.36
							<b>Total</b>	<b>\$3,937.58</b>