



Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	5,150	3,901	6,200	15,251	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,150	3,901	6,200	15,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.85%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 12/20/1980

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 3,140

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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	151,844	19,883	6,200	177,927		177,927		177,927		1
2	Food Purchase		125,184		125,184		125,184		125,184		2
3	Housekeeping	63,229	15,947		79,176		79,176		79,176		3
4	Laundry	81,837	7,354		89,191		89,191		89,191		4
5	Heat and Other Utilities			83,712	83,712		83,712		83,712		5
6	Maintenance	53,721			53,721		53,721		53,721		6
7	Other (specify):* <b>Trash removal and Se</b>			16,626	16,626		16,626		16,626		7
8	<b>TOTAL General Services</b>	350,631	168,368	106,538	625,537		625,537		625,537		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,250	19,250		19,250		19,250		9
10	Nursing and Medical Records	1,253,598	78,383	6,935	1,338,916		1,338,916		1,338,916		10
10a	Therapy			424,953	424,953		424,953		424,953		10a
11	Activities	53,739	374	1,363	55,476		55,476		55,476		11
12	Social Services	73,276		1,363	74,639		74,639		74,639		12
13	CNA Training										13
14	Program Transportation			2,950	2,950		2,950		2,950		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,380,613	78,757	456,814	1,916,184		1,916,184		1,916,184		16
	<b>C. General Administration</b>										
17	Administrative	123,193			123,193		123,193		123,193		17
18	Directors Fees										18
19	Professional Services			178,741	178,741		178,741		178,741		19
20	Dues, Fees, Subscriptions & Promotions			14,814	14,814		14,814		14,814		20
21	Clerical & General Office Expenses	52,120	18,458	63,848	134,426		134,426	(52,626)	81,800		21
22	Employee Benefits & Payroll Taxes			424,217	424,217		424,217	(144)	424,073		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,815	2,815		2,815		2,815		24
25	Other Admin. Staff Transportation			485	485		485		485		25
26	Insurance-Prop.Liab.Malpractice			57,845	57,845		57,845		57,845		26
27	Other (specify):* <b>Advertising and Mark</b>			4,984	4,984		4,984	(4,984)			27
28	<b>TOTAL General Administration</b>	175,313	18,458	747,749	941,520		941,520	(57,754)	883,766		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,906,557	265,583	1,311,101	3,483,241		3,483,241	(57,754)	3,425,487		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hallmark House Nursing Ctr

#0036343

Report Period Beginning:

01/01/18

Ending:

12/31/18

## 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			69,350	69,350		69,350		69,350			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,384	19,384		19,384		19,384			32
33	Real Estate Taxes			36,805	36,805		36,805		36,805			33
34	Rent-Facility & Grounds			310,901	310,901		310,901		310,901			34
35	Rent-Equipment & Vehicles			4,242	4,242		4,242		4,242			35
36	Other (specify):* <b>Amortization</b>			7,581	7,581		7,581	(7,548)	33			36
37	<b>TOTAL Ownership</b>			448,263	448,263		448,263	(7,548)	440,715			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		652	172,069	172,721		172,721		172,721			39
40	Barber and Beauty Shops	9,221		216	9,437		9,437	(9,437)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,345	110,345		110,345		110,345			42
43	Other (specify):* <b>Gift Expense</b>			35,676	35,676		35,676	(35,676)				43
44	<b>TOTAL Special Cost Centers</b>	9,221	652	318,306	328,179		328,179	(45,113)	283,066			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,915,778	266,235	2,077,670	4,259,683		4,259,683	(110,415)	4,149,268			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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				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	(1,495)	21		18
19	Entertainment				19
20	Contributions	(250)	27		20
21	Owner or Key-Man Insurance	(144)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,131)	21		24
25	Fund Raising, Advertising and Promotional	(4,734)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,548)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(45,113)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (110,415)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)		VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (110,415)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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

<b>BHF USE ONLY</b>							
48		49		50		51	52

Hallmark House Nursing Ctr

ID# 0036343

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Independent Living	\$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Other Non-Reimbursable costs	(35,676)	43	3
4	Barber & Beauty	(9,437)	40	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	<b>Total</b>	(45,113)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>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	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	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>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>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	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(52,626)	0	0	0	0	0	0	0	0	0	0	(52,626)	21
22	Employee Benefits & Payroll Taxes	(144)	0	0	0	0	0	0	0	0	0	0	(144)	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	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):*	(4,984)	0	0	0	0	0	0	0	0	0	0	(4,984)	27
28	<b>TOTAL General Administration</b>	<b>(57,754)</b>	<b>0</b>	<b>(57,754)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(57,754)</b>	<b>0</b>	<b>(57,754)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(7,548)	0	0	0	0	0	0	0	0	0	0	(7,548)	36
37	<b>TOTAL Ownership</b>	<b>(7,548)</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>(7,548)</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	(9,437)	0	0	0	0	0	0	0	0	0	0	(9,437)	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):*	(35,676)	0	0	0	0	0	0	0	0	0	0	(35,676)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(45,113)</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>(45,113)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(110,415)</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>(110,415)</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	25%					
Kim Lane Trust	25%					
Leslie Miller Trust	25%					
Brandon Miller trust	25%					

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	19 Management Fees	\$ 90,000	Advanced Capital Management	100.00%	\$ 90,000	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 90,000			\$ 90,000	\$ *	14

\* 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:

01/01/18

Ending:

12/31/18

**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	N/A							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

01/01/18

Ending: 12/31/18

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	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 01/01/18 Ending: 12/31/18

**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																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	NOTE PAYABLE BUSEY	X	WORKING CAPITAL			243,181			19,384	6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$ 243,181			\$ 19,384	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>					\$ 243,181			\$ 19,384	15										

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2017 report.		\$	<b>35,380</b>	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.)		\$	<b>36,562</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,182</b>	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>35,623</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>36,805</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	<b>34,072</b>	8	
	2014	<b>34,813</b>	9	
	2015	<b>35,111</b>	10	
	2016	<b>35,834</b>	11	
	2017	<b>36,562</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Hallmark House Nursing Ctr COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Debbie McDonald

TELEPHONE 309-347-3121 X 225 FAX #: 309-347-607

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>04-10-01-407-018</u>	<u>LTC Facility</u>	\$ <u>                    </u>	\$ <u>36,561.96</u>
2. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
	<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>36,561.96</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**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:

01/01/18

Ending:

12/31/18

**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).

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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 Use	2 Square Feet	3 Year Acquired	4 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>

Facility Name & ID Number Hallmark House Nursing Ctr

# 0036343

Report Period Beginning:

01/01/18

Ending:

12/31/18

**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	\$		\$	\$	\$
5			1980	1976	290,586					
6										
7										
8										
	<b>Improvement Type**</b>									
9	Building Improvements		1977		41,421					
10	Building Improvements		1978		6,473					
11	Building Improvements		1981		10,987					
12	Building Improvements		1982		12,368					
13	Building Improvements		1983		7,662					
14	Building Improvements		1984		2,343					
15	Building Improvements		1986		17,604					
16	Building Improvements		1987		7,275					
17	Building Improvements		1988		42,911					
18	Building Improvements		1989		15,387					
19	Building Improvements		1990		55,198					
20	Building Improvements		1991		11,136					
21	Building Improvements		1993		53,652					
22	Building Improvements		1994		45,374					
23	Building Improvements		1995		110,087					
24	Building Improvements		1996		26,910					
25	Building Improvements		1997		43,197					
26	Building Improvements		1998		118,189					
27	Building Improvements		1999		29,258					
28	Building Improvements		2000		253,531					
29	Building Improvements		2001		21,498					
30	Building Improvements		2002		22,175					
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hallmark House Nursing Ctr# 0036343

Report Period Beginning:

01/01/18

Ending:

12/31/18**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodel bathroom	2003	\$ 2,237	\$	20	\$	\$	\$	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20				38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20				39
40	Griddle Exhaust	2003	2,076		20				40
41	Circuits & Outlets	2003	2,926		20				41
42	Heater in room 116	2003	1,100		20				42
43	Kitchen Remodel	2003	5,967		20				43
44	Blinds	2003	833		20				44
45	Boiler Pump	2003	1,694		20				45
46	Boiler Repair	2003	2,247		20				46
47	Glass Doors	2003	1,602		20				47
48	Boiler	2003	1,154		20				48
49	Lighting	2004	610		20				49
50	Blinds, Valance	2004	8,175		20				50
51	Light Fixture	2004	759		20				51
52	Blinds & vallance	2004	9,773		20				52
53	Boiler	2004	4,586		20				53
54	Outside lighting	2004	3,155		20				54
55	Roof	2004	4,419		20				55
56	Bathroom remodel	2004	1,054		20				56
57	Cabinets & countertop	2004	890		20				57
58	Bathroom flooring	2004	546		20				58
59	Air conditioner	2004	3,278		20				59
60	Bathroom remodel	2004	2,000		20				60
61	Cabinets & countertop	2004	460		20				61
62	Cabinets in beverage centger	2004	250		20				62
63	Houthous	2004	7,929		20				63
64	Fire Door	2004	879		20				64
65	Hot water heater	2004	650		20				65
66	Tub repairs	2004	539		20				66
67	Tub repairs	2004	500		20				67
68	Door locks	2004	985		20				68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,834,235	\$		\$	\$	\$	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:

01/01/18

Ending:

12/31/18**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	\$		\$	\$	\$	1
2	Exhaust fan repairs	2004	717		20				2
3	Water heater repairs	2004	720		20				3
4	Plumbing repairs	2004	5,620		20				4
5	Garbage Disposals	2004	850		20				5
6	Storage room remodel	2004	696		20				6
7	Room Remodel	2004	4,496		20				7
8	Back sidewalk	2005	1,600		20				8
9	Fire door	2005	487		20				9
10	Front sidewalk	2005	1,700		20				10
11	Fire Dampers.	2005	747		20				11
12	Irrigation System	2005	7,750		20				12
13	Landscaping	2005	942		20				13
14	Landscaping	2005	6,028		20				14
15	Fish pond	2005	5,027		20				15
16	Office floor	2005	319		20				16
17	Walk in cooler floor	2005	800		20				17
18	Walk in freezer floor	2005	540		20				18
19	Water system pump	2005	852		20				19
20	Breaker panel replacement	2005	1,952		20				20
21	Public bath tile	2005	219		20				21
22	Wire fish pond	2005	1,016		20				22
23	Detectors	2005	860		20				23
24	Gutters	2005	2,375		20				24
25	Mixing valve	2005	714		20				25
26	Blacktop repair	2005	1,846		20				26
27	Blacktop repair	2005	320		20				27
28	Wire outside lights	2006	1,145		20				28
29	Plywood for Air lock ceiling	2006	123		20				29
30	Install entry for air lock	2006	3,935		20				30
31	Door for air lock	2006	3,028		20				31
32	Dining outlet	2006	155		20				32
33	Exhaust fan & rewire junction	2006	1,633		20				33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,893,447	\$		\$	\$	\$	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:

01/01/18

Ending:

12/31/18**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	\$		\$	\$	\$	1
2	Outlet for steamer in kitchen	2006	381		20				2
3	Remodeol bathroom 129	2006	508		20				3
4	Cabinets for bath in Rm 129	2006	946		20				4
5	Install sink in janitor closet	2006	1,500		20				5
6	Plumbing for bathroom	2006	1,350		20				6
7	Cabinets for bath	2006	443		20				7
8	Replace flooring in rm 129 bath	2006	370		20				8
9	New door nurses station	2006	1,314		20				9
10	Reroof east end	2006	4,928		20				10
11	Flooring shower room	2006	1,565		20				11
12	Ada door opener downpay	2006	512		20				12
13	Ada door opener	2006	1,536		20				13
14	New activity room door	2006	1,710		20				14
15	New carpeting	2006	11,500		20				15
16	Tile bathroom remodel	2006	371		20				16
17	Sidewalk	2006	243		20				17
18	Sidewalk in front	2006	757		20				18
19	Bathroom flooring Rm 114	2006	465		20				19
20	Cabinets for bathroom	2006	1,168		20				20
21	Bathroom remoded rm 114	2006	350		20				21
22	Plywood reroof east end	2006	1,689		20				22
23	Carpeting	2006	11,500		20				23
24	Install exit signs for LSC survey	2006	1,843		20				24
25	Doors	2007	6,052		20				25
26	Carpeting	2007	11,000		20				26
27	Tile work	2007	2,930		20				27
28	Hood systems to alarm	2007	1,836		20				28
29	Electrical work	2007	2,961		20				29
30	Vent air conditioner hall	2007	1,140		20				30
31	Folding doors	2007	4,236		20				31
32	AC Dining room	2007	5,800		20				32
33	Bathroom	2007	15,450		20				33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,991,801	\$		\$	\$	\$	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:

01/01/18

Ending:

12/31/18**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	\$		\$	\$	\$	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20				2
3	Plumbing return line	2008	2,875		20				3
4	Boiler	2008	5,631		20				4
5	AC basement office	2008	452		20				5
6	SPA tile	2008	3,530		20				6
7	Walk in	2008	29,462		20				7
8	Heat pkg dining room	2008	301		20				8
9	Install fans in kitchen	2008	1,650		20				9
10	Install grease trap	2008	1,894		20				10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20				11
12	Lighting	2010	12,987		40				12
13	Generator	2010	48,199		10				13
14	Kitchen air conditioner	2011	14,198		40				14
15	Heating unit	2011	3,783		40				15
16	Tankless water heaters (2)	2011	6,500		10				16
17	Roof over dining room	2011	17,885		40				17
18	Doors for Gazebo entrance	2011	5,018		40				18
19	Hallway lighting	2011	3,575		40				19
20	Therapy door	2011	4,470		40				20
21	Expansion joints repair	2011	2,806		40				21
22	Roof on Admin . Bldg.	2012	15,456		20				22
23	Sidewalks in front of facility	2012	8,850		20				23
24	Boiler	2012	16,885		20				24
25	Parking lot expansion	2013	49,995		20				25
26	Dining room remodel	2013	5,689		40				26
27	Fire system upgrade	2013	6,347		10				27
28	Air Conditioner Unit	2015	8,860		39				28
29	Indoor/OH Sprinkler System	2015	8,520		39				29
30	Cooling Units - Attached to Building	2018	2,580		39				30
31									31
32	As Per Pekin Investment Group, LLC			38,000		38,000		819,123	32
33	As Per Hallmark House Nursing Center			17,733		17,733		738,801	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,318,644	\$ 55,733		\$ 55,733	\$	\$ 1,557,924	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	\$ 386,683	\$ 32,992	\$ 32,992	\$	Various	\$ 231,482	71
72	Current Year Purchases	10,765	694	694		Various	694	72
73	Fully Depreciated Assets	579,883				Various	579,883	73
74								74
75	TOTALS	\$ 977,331	\$ 33,686	\$ 33,686	\$		\$ 812,059	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Van 2016	2016	\$ 47,195	\$ 9,439	\$ 9,439	\$	5	\$ 23,598	76
77	Facility	2007 Chevy HHR	2007	18,012				5	18,012	77
78	Facility	2015 Ford Explorer	2015	42,459	8,492	8,492		5	33,260	78
79										79
80	TOTALS			\$ 107,666	\$ 17,931	\$ 17,931	\$		\$ 74,870	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)	\$ 3,460,641	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,350	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,444,853	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.

Facility Name & ID Number

Hallmark House Nursing Ctr

# 0036343

Report Period Beginning: 01/01/18

Ending: 12/31/18

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Pekin Investment Group

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:	1980	71	5/1/90	\$ 310,901	5	20	3
4	Additions							4
5								5
6								6
7	TOTAL		71		\$ 310,901			7

10. Effective dates of current rental agreement:

Beginning 3/31/16

Ending 3/31/21

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. 0  
 This amount was calculated by dividing the total amount to be amortized 0  
 by the length of the lease 0.

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: \$ 4,242 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.

**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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	0.00 hrs	\$ 0	4,627	\$ 198,287	\$ 0	4,627	\$ 198,287	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	278	19,325	0	278	19,325	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	3,823	207,341	0	3,823	207,341	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	0.00 hrs	0	0	0	0			8
9	Pharmacy	V39	0.00 # of prescrpts	0	0	0	140,787		140,787	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>LAB/RADIOLOGY</u>	V39	0.00	0	0	0	31,282		31,282	12
13	Other (specify): <u>BILLABLE SUPPLIES</u>	V39	0.00	0	0	0	652		652	13
14	<b>TOTAL</b>			\$	8,728	\$ 424,953	\$ 172,721	8,728	\$ 597,674	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Hallmark House Nursing Ctr**

# **0036343**

Report Period Beginning: **01/01/18**

Ending:

**12/31/18**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/18**

(last day of reporting year)

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	\$ 305,944	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	251,301		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,151		6
7	Other Prepaid Expenses	690		7
8	Accounts Receivable (owners or related parties)	21,234		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 582,320	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	210,125		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	910,186		15
16	Equipment, at Historical Cost	1,084,998		16
17	Accumulated Depreciation (book methods)	(1,625,730)		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>	\$ 579,579	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,161,899	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 186,355	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,398		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,187		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,320		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<b>Other</b>	2,848		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 341,108	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	243,181		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>	\$ 243,181	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 584,289	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 577,610	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,161,899	\$	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>1,275,146</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</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>1,275,146</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(309,349)	<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	(40,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PY Income Activity</b>	(309,354)	<b>15</b>
<b>16</b>	Other (describe) <b>PY Adjustment</b>	(38,833)	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (697,536)	<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>577,610</b>	<b>24</b> *

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

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,981,509	1
2	Discounts and Allowances for all Levels	(1,065,999)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,915,510	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,854,470	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,854,470	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	140,787	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,425	19
20	Radiology and X-Ray	4,498	20
21	Other Medical Services	4,644	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 180,354	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>AL/IL</u>		28
28a	<u>Misc Revenue</u>		28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,950,334	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	625,537	31
32	Health Care	1,916,184	32
33	General Administration	941,520	33
<b>B. Capital Expense</b>			
34	Ownership	448,263	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	217,834	35
36	Provider Participation Fee	110,345	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,259,683	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(309,349)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (309,349)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 679,888	44
45	Private Pay - Net Inpatient Revenue	862,272	45
46	Medicare - Net Inpatient Revenue	1,479,241	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	840,615	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(1,946,506)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,915,510	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:

01/01/18

Ending:

12/31/18

**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	1,936	2,120	\$ 80,732	\$ 38.08	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	11,053	11,443	302,048	26.40	3
4	Licensed Practical Nurses	11,026	11,752	285,513	24.29	4
5	CNAs & Orderlies	44,326	45,928	550,208	11.98	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,920	2,064	29,813	14.44	9
10	Activity Assistants	2,456	2,600	23,926	9.20	10
11	Social Service Workers	3,510	3,702	73,276	19.79	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	2,027	2,189	37,111	16.95	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	11,815	12,205	114,733	9.40	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,050	2,190	53,721	24.53	17
18	Housekeepers	6,664	6,799	63,229	9.30	18
19	Laundry	6,870	7,305	81,837	11.20	19
20	Administrator	1,789	1,960	123,193	62.85	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,964	2,088	52,120	24.96	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,960	2,088	35,097	16.81	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	581	602	9,221	15.32	33
34	TOTAL (lines 1 - 33)	111,947	117,035	\$ 1,915,778 *	\$ 16.37	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	\$ 6,200	V01-3	35
36	Medical Director	19,250	V09-3	36
37	Medical Records Consultant	2,080	V10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,855	V10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	1,363	V11-3	44
45	Social Service Consultant	1,363	V12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 35,111		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number **Hallmark House Nursing Ctr**

# **0036343**

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

**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	
Laurie Reed	Administrator	0	\$ 123,193	Workers' Compensation Insurance	\$ 34,664	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	12,475	
				FICA Taxes	212,606	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	176,803	Maintenance Subscriptions/Dues	965	
				Employee Meals		Activities Subscriptions/Dues	73	
				Illinois Municipal Retirement Fund (IMRF)*		Social Services Subscriptions/Dues	1,220	
						Admin Subscriptions/Dues	81	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,193			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 424,073	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,814	
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
RSM US LLP	Accounting Fees		\$ 19,290	N/A		\$	Out-of-State Travel	\$
HAWKES & HASTINGS ACCOUNTING	Accounting Fees		2,300				Booking Website	247
PLANTE & MORAN, PLLC	Accounting Fees		5,300				American Red Cross	300
Providigm, LLC	Data Processing		2,280				In-State Travel	
L.W. Miller Advanced Capital	Management Fee		90,000					
See PG21-Supp	Data Processing		59,571				Seminar Expense	
							ILHCA	1,645
							INHAA	400
							Health Services Consultating Seminar	223
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 178,741	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,815

\* Attach copy of IMRF notifications

\*\*See instructions.

STATE OF ILLINOIS		PG21-Supp
Facility Name & ID Number	#0036343	Report Period Beginning: 01/01/18 Ending: 12/31/18
<b>XIX. SUPPORT SCHEDULES</b>		
<b>C. Professional Services</b>		
<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
<u>FEDERAL COMPANIES</u>	<u>Data Processing</u>	\$ 837
<u>PCC TECHNOLOGIES, INC</u>	<u>Data Processing</u>	27,435
<u>ABILITY NETWORK INC.</u>	<u>Data Processing</u>	6,831
<u>KRONOS</u>	<u>Data Processing</u>	14,727
<u>ITV3</u>	<u>Data Processing</u>	1,624
<u>US INTERNET</u>	<u>Data Processing</u>	414
<u>SEAN MIKEL</u>	<u>Data Processing</u>	7,054
<u>NETWORK SOLUTIONS</u>	<u>Data Processing</u>	411
<u>DOMAIN LISTINGS, LLC</u>	<u>Data Processing</u>	228
<u>AMAZON</u>	<u>Data Processing</u>	10
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		
<b>(For legal fee disclosure, see page 39 of instructions)</b>		\$ 59,571

