FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0036343

Facility Name: Hallmark House Nursing Center

Address: 2501 Allentown Road (Number) Pekin (City) 61554 (Zip Code)

County: Tazwell

Telephone Number: 309-347-3121 **Fax #** 309-347-3607

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Margel S. Peddicord, CPA **Telephone Number:** 217-787-8554
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Margel S. Peddicord, CPA
(Firm Name & Address) Margel S. Peddicord, CPA, 5300 Jaeger Dr., Springfield, IL 62711
(Telephone) 217-787-8554 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,613	9,905	5,386	22,904	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,613	9,905	5,386	22,904	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.38%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/20/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 4,556

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	249,464	22,379	54,775	**326,617**		**326,617**	**(84,252)**	**242,365**			1
2	Food Purchase		241,383		**241,383**	**(35,791)**	**205,592**	**(47,938)**	**157,654**			2
3	Housekeeping	135,887	22,048	3,493	**161,428**		**161,428**		**161,428**			3
4	Laundry	45,892	18,031	3,502	**67,425**		**67,425**		**67,425**			4
5	Heat and Other Utilities			94,722	**94,722**		**94,722**		**94,722**			5
6	Maintenance	57,463	8,988	108,948	**175,399**		**175,399**		**175,399**			6
7	Other (specify):*											7
8	**TOTAL General Services**	**488,706**	**312,828**	**265,439**	**1,066,973**	**(35,791)**	**1,031,182**	**(132,190)**	**898,992**			8
	B. Health Care and Programs											
9	Medical Director			6,500	**6,500**		**6,500**		**6,500**			9
10	Nursing and Medical Records	1,514,011	86,470	65,752	**1,666,233**	**(23,366)**	**1,642,867**		**1,642,867**			10
10a	Therapy	67,286		316,265	**383,550**		**383,550**		**383,550**			10a
11	Activities	73,312	2,989	11,997	**88,298**		**88,298**	**(7,336)**	**80,962**			11
12	Social Services	**32,715**	**50**	**1,298**	**34,063**		**34,063**		**34,063**			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	**1,687,324**	**89,509**	**401,811**	**2,178,644**	**(23,366)**	**2,155,278**	**(7,336)**	**2,147,942**			16
	C. General Administration											
17	Administrative	**91,534**		**144,000**	**235,534**		**235,534**		**235,534**			17
18	Directors Fees											18
19	Professional Services			**20,432**	**20,432**		**20,432**	**1,100**	**21,532**			19
20	Dues, Fees, Subscriptions & Promotions			**36,406**	**36,406**		**36,406**	**(9,147)**	**27,259**			20
21	Clerical & General Office Expenses	**65,527**	**13,903**	**67,310**	**146,740**	**(9,985)**	**136,755**	**(815)**	**135,940**			21
22	Employee Benefits & Payroll Taxes			**338,749**	**338,749**	**35,791**	**374,540**		**374,540**			22
23	Inservice Training & Education											23
24	Travel and Seminar			**6,239**	**6,239**	**9,985**	**16,224**		**16,224**			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			**40,403**	**40,403**		**40,403**		**40,403**			26
27	Other (specify):*			**67,425**	**67,425**		**67,425**		**67,425**			27
28	**TOTAL General Administration**	**157,061**	**13,903**	**720,964**	**891,928**	**35,791**	**927,719**	**(8,862)**	**918,857**			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	**2,333,090**	**416,240**	**1,388,215**	**4,137,545**	**(23,366)**	**4,114,179**	**(148,388)**	**3,965,791**			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 Center #0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			25,600	25,600		25,600	60,304	85,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,296	4,296		4,296	30,648	34,944			32
33	Real Estate Taxes			31,953	31,953		31,953		31,953			33
34	Rent-Facility & Grounds			267,077	267,077		267,077	(267,077)				34
35	Rent-Equipment & Vehicles			5,249	5,249		5,249		5,249			35
36	Other (specify):* **Amortization**							460	460			36
37	**TOTAL Ownership**			334,175	334,175		334,175	(175,665)	158,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,585	4,560	196,145		196,145		196,145			39
40	Barber and Beauty Shops					23,366	23,366	(1,834)	21,532			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,480	68,480		68,480		68,480			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		191,585	73,040	264,625	23,366	287,991	(1,834)	286,157			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,333,090	607,825	1,795,430	4,736,345		4,736,345	(325,887)	4,410,458			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 Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(82,289)	1		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	47,317	30		9
10	Interest and Other Investment Income	(8,605)	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				24
25	Fund Raising, Advertising and Promotional	(4,312)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(445)	20		28
29	Other-Attach Schedule See page 5A	(64,276)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,610)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(213,277)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (213,277)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (325,887)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Hallmark House Nursing Center

ID# 0036343

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset barber & beauty income against expense	$ (1,834)	40	1
2	Catering advertising expense	(4,390)	20	2
3	Catering food expense	(47,938)	2	3
4	Remove soda and avon cost	(7,336)	11	4
5	Remove vending expense	(1,963)	1	5
6	Remove marketing expense	(815)	21	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(64,276)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Center **#** 0036343 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(84,252)	0	0	0	0	0	0	0	0	0	0	(84,252)	1
2	Food Purchase	(47,938)	0	0	0	0	0	0	0	0	0	0	(47,938)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(132,190)	0	0	0	0	0	0	0	0	0	0	(132,190)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,336)	0	0	0	0	0	0	0	0	0	0	(7,336)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,336)	0	0	0	0	0	0	0	0	0	0	(7,336)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,100	0	0	0	0	0	0	0	0	0	1,100	19
20	Fees, Subscriptions & Promotions	(9,147)	0	0	0	0	0	0	0	0	0	0	(9,147)	20
21	Clerical & General Office Expenses	(815)	0	0	0	0	0	0	0	0	0	0	(815)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,962)	1,100	0	0	0	0	0	0	0	0	0	(8,862)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(149,488)	1,100	0	0	0	0	0	0	0	0	0	(148,388)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hallmark House Nursing Center # 0036343 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	47,317	12,987	0	0	0	0	0	0	0	0	0	60,304	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,605)	39,253	0	0	0	0	0	0	0	0	0	30,648	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(267,077)	0	0	0	0	0	0	0	0	0	(267,077)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	460	0	0	0	0	0	0	0	0	0	460	36
37	TOTAL Ownership	38,712	(214,377)	0	0	0	0	0	0	0	0	0	(175,665)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,834)	0	0	0	0	0	0	0	0	0	0	(1,834)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,834)	0	0	0	0	0	0	0	0	0	0	(1,834)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(112,610)	(213,277)	0	0	0	0	0	0	0	0	0	(325,887)	45

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mr. Lloyd Miller	100%			Advanced Capital	Walnut Creek	Management Co.
				Pekin Investment	Pekin	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 267,077	Pekin Investment Group, LLC	100.00%	$	$ (267,077)	1
2	V	19	Professional fees		Pekin Investment Group, LLC	100.00%	1,100	1,100	2
3	V	32	Interest		Pekin Investment Group, LLC	100.00%	39,253	39,253	3
4	V	30	Depreciation		Pekin Investment Group, LLC	100.00%	12,987	12,987	4
5	V	36	Amortization		Pekin Investment Group, LLC	100.00%	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			$ 267,077			$ 53,800	$ * (213,277)	14

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lloyd Miller	Owner	Management	100.00	0	25	0.63	Mgt. Fee	$ 144,000	17-3	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	$ 144,000		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 Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	Mortgage			$	$			$ 39,253	1
2	First National Bank		X	Van Loan							885	2
3	First National Bank		X	HHR Loan							300	3
4												4
5												5
	Working Capital											
6	Credit Accounts		X	Working Capital							2,481	6
7	Busey Bank		X	Line of Credit							630	7
8												8
9	TOTAL Facility Related						$	$			$ 43,549	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 43,549	15

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

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

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 33,774	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.)		$ 32,838	2
3. Under or (over) accrual (line 2 minus line 1).		$ (936)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,889	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 31,953	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	28,662	8
2006	29,522	9
2007	30,157	10
2008	31,953	11
2009	32,838	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Center COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Margel S.Peddicord, CPA

TELEPHONE 217-787-8554 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-10-01-407-018	LTC Facility	$ 32,838.00	$ 32,838.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,838.00	$ 32,838.00

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: 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		292,455		$ 57,000	1
2					2
3	TOTALS	292,455		$ 57,000	3

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1980	1976	$ 510,430	$ 12,988	40	$ 12,761	$ (227)	$ 306,261	4
5											5
6			1980	1976	290,586		40	7,265	7,265	167,101	6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1977	41,421		20	1,035	1,035	25,881	9
10	Building Improvements			1978	6,473		20			6,473	10
11	Building Improvements			1981	10,987		20	275	275	6,871	11
12	Building Improvements			1982	12,368		20	309	309	7,728	12
13	Building Improvements			1983	7,662		20	191	191	4,780	13
14	Building Improvements			1984	2,343		20	58	58	1,454	14
15	Building Improvements			1986	17,604		20	482	482	11,742	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	770	770	15,590	18
19	Building Improvements			1990	55,198		20	1,464	1,464	29,280	19
20	Building Improvements			1991	11,136		20	417	417	10,776	20
21	Building Improvements			1993	53,652		20	528	528	20,679	21
22	Building Improvements			1994	45,374		20	2,784	2,784	45,936	22
23	Building Improvements			1995	110,087		20	4,438	4,438	70,856	23
24	Building Improvements			1996	26,910		20	450	450	17,526	24
25	Building Improvements			1997	43,197		20	2,250	2,250	37,532	25
26	Building Improvements			1998	118,189		20	5,994	5,994	74,926	26
27	Building Improvements			1999	29,258		20	897	897	21,098	27
28	Building Improvements			2000	253,531		20	9,642	9,642	112,131	28
29	Building Improvements			2001	21,498		20	1,312	1,312	13,120	29
30	Building Improvements			2002	22,175		20	1,755	1,755	15,795	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remodel bathroom	2003	$ 2,237	$	20	$ 112	$ 112	$ 896	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	1,576	38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20	68	68	547	39
40	Griddle Exhaust	2003	2,076		20	104	104	1,039	40
41	Circuits & Outlets	2003	2,926		20	146	146	1,170	41
42	Heater in room 116	2003	1,100		20	55	55	440	42
43	Kitchen Remodel	2003	5,967		20	298	298	2,386	43
44	Blinds	2003	833		20	42	42	334	44
45	Boiler Pump	2003	1,694		20	85	85	650	45
46	Boiler Repair	2003	2,247		20	112	112	824	46
47	Glass Doors	2003	1,602		20	80	80	560	47
48	Boiler	2003	1,154		20	58	58	308	48
49	Lighting	2004	610		20	31	31	215	49
50	Blinds, Valance	2004	8,175		20	409	409	3,098	50
51	Light Fixture	2004	759		20	38	38	266	51
52	Blinds & vallance	2004	9,773		20	489	489	3,655	52
53	Boiler	2004	4,586		20	229	229	1,605	53
54	Outside lighting	2004	3,155		20	158	158	1,105	54
55	Roof	2004	4,419		20	221	221	1,547	55
56	Bathroom remodel	2004	1,054		20	53	53	369	56
57	Cabinets & countertop	2004	890		20	45	45	313	57
58	Bathroom flooring	2004	546		20	27	27	191	58
59	Air conditioner	2004	3,278		20	164	164	1,148	59
60	Bathroom remodel	2004	2,000		20	100	100	700	60
61	Cabinets & countertop	2004	460		20	23	23	161	61
62	Cabinets in beverage centger	2004	250		20	13	13	89	62
63	Houthous	2004	7,929		20	396	396	2,774	63
64	Fire Door	2004	879		20	44	44	308	64
65	Hot water heater	2004	650		20	33	33	229	65
66	Tub repairs	2004	539		20	27	27	189	66
67	Tub repairs	2004	500		20	25	25	108	67
68	Door locks	2004	985		20	49	49	345	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,834,235	$ 12,988		$ 59,008	$ 46,020	$ 1,102,867	70

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,834,235	$ 12,988		$ 59,008	$ 46,020	$ 1,102,867	1
2	Exhaust fan repairs	2004	717		20	36	36	252	2
3	Water heater repairs	2004	720		20	36	36	252	3
4	Plumbing repairs	2004	5,620		20	281	281	1,967	4
5	Garbage Disposals	2004	850		20	43	43	299	5
6	Storage room remodel	2004	696		20	35	35	244	6
7	Room Remodel	2004	4,496		20	225	225	1,574	7
8	Back sidewalk	2005	1,600		20	80	80	480	8
9	Fire door	2005	487		20	24	24	146	9
10	Front sidewalk	2005	1,700		20	85	85	510	10
11	Fire Dampers.	2005	747		20	37	37	224	11
12	Irrigation System	2005	7,750		20	388	388	2,326	12
13	Landscaping	2005	942		20	47	47	282	13
14	Landscaping	2005	6,028		20	301	301	1,805	14
15	Fish pond	2005	5,027		20	251	251	1,508	15
16	Office floor	2005	319		20	16	16	96	16
17	Walk in cooler floor	2005	800		20	40	40	240	17
18	Walk in freezer floor	2005	540		20	27	27	215	18
19	Water system pump	2005	852		20	43	43	256	19
20	Breaker panel replacement	2005	1,952		20	98	98	586	20
21	Public bath tile	2005	219		20	11	11	66	21
22	Wire fish pond	2005	1,016		20	51	51	306	22
23	Detectors	2005	860		20	43	43	258	23
24	Gutters	2005	2,375		20	119	119	714	24
25	Mixing valve	2005	714		20	36	36	214	25
26	Blacktop repair	2005	1,846		20	92	92	553	26
27	Blacktop repair	2005	320		20	16	16	96	27
28	Wire outside lights	2006	1,145		20	57	57	286	28
29	Plywood for Air lock ceiling	2006	123		20	6	6	30	29
30	Install entry for air lock	2006	3,935		20	197	197	985	30
31	Door for air lock	2006	3,028		20	151	151	756	31
32	Dining outlet	2006	155		20	8	8	40	32
33	Exhaust fan & rewire junction	2006	1,633		20	82	82	409	33
34	TOTAL (lines 1 thru 33)		$ 1,893,447	$ 12,988		$ 61,970	$ 48,982	$ 1,120,842	34

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,893,447	$ 12,988		$ 61,970	$ 48,982	$ 1,120,842	1
2	Outlet for steamer in kitchen	2006	381		20	19	19	95	2
3	Remodeol bathroom 129	2006	508		20	25	25	126	3
4	Cabinets for bath in Rm 129	2006	946		20	47	47	236	4
5	Install sink in janitor closet	2006	1,500		20	75	75	375	5
6	Plumbing for bathroom	2006	1,350		20	68	68	339	6
7	Cabinets for bath	2006	443		20	22	22	110	7
8	Replace flooring in rm 129 bath	2006	370		20	19	19	94	8
9	New door nurses station	2006	1,314		20	66	66	329	9
10	Reroof east end	2006	4,928		20	246	246	1,231	10
11	Flooring shower room	2006	1,565		20	78	78	391	11
12	Ada door opener downpay	2006	512		20	26	26	129	12
13	Ada door opener	2006	1,536		20	77	77	385	13
14	New activity room door	2006	1,710		20	86	86	429	14
15	New carpeting	2006	11,500		20	575	575	2,875	15
16	Tile bathroom remodel	2006	371		20	19	19	94	16
17	Sidewalk	2006	243		20	12	12	60	17
18	Sidewalk in front	2006	757		20	38	38	190	18
19	Bathroonm flooring Rm 114	2006	465		20	23	23	116	19
20	Cabinets for bathroom	2006	1,168		20	58	58	291	20
21	Bathroom remoded rm 114	2006	350		20	18	18	89	21
22	Plywood reroof east end	2006	1,689		20	84	84	421	22
23	Carpeting	2006	11,500		20	575	575	2,875	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	460	24
25	Doors	2007	6,052		20	303	303	1,211	25
26	Carpeting	2007	11,000		20	550	550	2,200	26
27	Tile work	2007	2,930		20	147	147	587	27
28	Hood systems to alarm	2007	1,836		20	92	92	368	28
29	Electrical work	2007	2,961		20	148	148	592	29
30	Vent air conditioner hall	2007	1,140		20	57	57	228	30
31	Folding doors	2007	4,236		20	212	212	848	31
32	AC Dining room	2007	5,800		20	290	290	1,160	32
33	Bathroom	2007	15,450		20	773	773	3,091	33
34	TOTAL (lines 1 thru 33)		$ 1,991,801	$ 12,988		$ 66,890	$ 53,902	$ 1,142,867	34

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,991,801	$ 12,988		$ 66,890	$ 53,902	$ 1,142,867	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20	1,486	1,486	4,458	2
3	Plumbing return line	2008	2,875		20	144	144	432	3
4	Boiler	2008	5,631		20	282	282	846	4
5	AC basement office	2008	452		20	23	23	69	5
6	SPA tile	2008	3,530		20	177	177	531	6
7	Walk in	2008	29,462		20	1,473	1,473	4,419	7
8	Heat pkg dining room	2008	301		20	15	15	45	8
9	Install fans in kitchen	2008	1,650		20	83	83	249	9
10	Install grease trap	2008	1,894		20	95	95	285	10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20	436	436	872	11
12	Lighting	2010	12,987		40	27	27	27	12
13	Generator	2010	48,199		10	2,008	2,008	2,008	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	TOTAL (lines 1 thru 33)		$ 2,137,227	$ 12,988		$ 73,139	$ 60,151	$ 1,157,106	34

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 83,171	$ 7,527	$ 7,680	$ 153		$ 66,450	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	582,461					582,461	73
74								74
75	TOTALS	$ 665,632	$ 7,527	$ 7,680	$ 153		$ 648,911	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Ford Wagon	1996	$ 35,576	$	$	$		$ 35,576	76
77	Facility	2007 Chevrolet G1500	2007	25,427	5,085	5,085			20,340	77
78										78
79										79
80	TOTALS			$ 61,003	$ 5,085	$ 5,085	$		$ 55,916	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,920,862	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,600	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,904	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 60,304	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,861,933	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2007 Chevrolet HHR	$ 18,012	$ 5,200	$ 16,231	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 18,012	$ 5,200	$ 16,231	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 Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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 ☒ X NO
16. Rental Amount for movable equipment: $ 5,249 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Hallmark House Nursing Center STATE OF ILLINOIS # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	373	$ 115,523	$ 1,294	373	$ 116,817	1
2	Licensed Speech and Language Development Therapist		hrs		11	14,329		11	14,329	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		403	127,225		403	127,225	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			191,585			191,585	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Massage Therapist				144	2,700		144	2,700	12
13	Other (specify): X-ray					4,560			4,560	13
14	TOTAL			$	931	$ 455,922	$ 1,294	931	$ 457,216	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 Center **#** 0036343 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 917,668	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	793,145		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	8,249		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,723		7
8	Accounts Receivable (owners or related parties)	10,531		8
9	Other(specify): Investments	222,461		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,954,777	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	819,830		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	816,100		16
17	Accumulated Depreciation (book methods)	(1,209,806)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 426,124	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,380,901	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 72,696	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	227,133		29
30	Accrued Salaries Payable	155,027		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,352		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,068		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Assessment tax to HFS	29,926		36
37	Accrued Mgt Fee	193,530		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 713,732	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,247		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,247	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 733,979	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,646,921	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,380,900	$	48

***(See instructions.)**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,279,348	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,279,348	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	378,777	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(11,204)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 367,573	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,646,921	24 *

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,228,064	1
2	Discounts and Allowances for all Levels	(321,033)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,907,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,870	13
14	Non-Patient Meals	163,868	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 179,738	23
	D. Non-Operating Revenue		
24	Contributions	388	24
25	Interest and Other Investment Income***	8,605	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,993	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	7,071	28
28a	See attached	12,289	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,360	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,115,122	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,066,973	31
32	Health Care	2,178,644	32
33	General Administration	891,928	33
	B. Capital Expense		
34	Ownership	334,175	34
	C. Ancillary Expense		
35	Special Cost Centers	264,625	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,736,345	40
41	**Income before Income Taxes (line 30 minus line 40)****	378,777	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 378,777	43

*** 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 Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,234	1,280	$ 39,252	$ 30.67	1
2	Assistant Director of Nursing	2,008	2,112	50,688	24.00	2
3	Registered Nurses	12,142	12,661	341,167	26.95	3
4	Licensed Practical Nurses	9,380	9,606	201,159	20.94	4
5	CNAs & Orderlies	59,248	62,923	703,503	11.18	5
6	CNA Trainees	1,432	1,547	14,917	9.64	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,112	34,045	16.12	9
10	Activity Assistants	3,907	3,984	39,350	9.88	10
11	Social Service Workers	1,944	2,112	34,932	16.54	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,113	49,052	23.21	13
14	Head Cook	5,743	6,075	65,326	10.75	14
15	Cook Helpers/Assistants	10,289	10,877	96,143	8.84	15
16	Dishwashers					16
17	Maintenance Workers	4,844	5,036	61,085	12.13	17
18	Housekeepers	13,819	14,397	135,309	9.40	18
19	Laundry	5,129	5,359	46,271	8.63	19
20	Administrator	1,960	2,112	91,534	43.34	20
21	Assistant Administrator					21
22	Other Administrative	5,420	5,946	148,014	24.89	22
23	Office Manager	1,817	1,954	30,221	15.47	23
24	Clerical	4,070	4,388	73,689	16.79	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	1,746	1,850	21,470	11.61	31
32	Other Health Care(specify)					32
33	Other(specify) Cosmetologist	1,888	2,114	23,269	11.01	33
34	TOTAL (lines 1 - 33)	151,996	160,558	$ 2,300,396 *	$ 14.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	121	$ 5,121	1-3	35
36	Medical Director		6,500	9-3	36
37	Medical Records Consultant	12	1,840	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	274	6,000	10-3	39
40	Physical Therapy Consultant	126	7,785	10a-3	40
41	Occupational Therapy Consultant	211	12,405	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	120	10a-3	43
44	Activity Consultant	24	1,320	11-3	44
45	Social Service Consultant	24	1,320	12-3	45
46	Other(specify)				46
47	Psychiatrist consultant	7	2,700	10-3	47
48					48
49	TOTAL (lines 35 - 48)	801	$ 45,111		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynn Brady	Administrator	0	$ 91,534
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,534

B. Administrative - Other

Description	Amount
Management Fee - Advanced Capital Management	$ 144,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 144,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Margel S. Peddicord, CPA	Cst Rpt & benchmrk Anal.	$ 3,960
Gordon, Stockman	Accounting	2,700
PENFlex Services	Admin Services	3,007
Plante Moran	Medicare Cost Rept	2,000
RSM McGladrey	Accounting	6,900
Pre-Pay Legal Service	Legal	900
Hunziker Law Group	Legal	685
Midwest Collections	Collections	156
Notary Assoc.	Notary Fee	124
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 20,432

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,515
Unemployment Compensation Insurance	25,957
FICA Taxes	178,128
Employee Health Insurance	58,514
Employee Meals	35,791
Illinois Municipal Retirement Fund (IMRF)*	
Insurance - Life	776
Employee uniforms	4,337
Employee physicals	3,522
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,540

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	3,296
Health Care Worker Background Check	
(Indicate # of checks performed 77)	2,014
Patient Background Checks 118	1,180
IHCA Dues	3,919
Misc dues & subscriptions	2,009
Advertising & promotion	9,147
Sales tax	9,918
License & certificates	943
Less: Public Relations Expense	( )
Non-allowable advertising	(8,702)
Yellow page advertising	(445)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,259

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	16,224
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,224

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 01/01/10 Ending: 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3,919**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **40,488** Line **10**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO 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 Departmen
during this cost report period. $ **68,480**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **35,791** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **130,227**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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? **No**
e. Are all vehicles stored at the nursing home during the night and all othe
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 ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

Hallmark House
Support Schedules - Travel and Seminar
For the Year Ended December 31, 2010

Month of Service	Name of Individual Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Classification	Cost
December	Erika Dunniway	DON	1/20/2011	Springfield	In-Depth Training for Wound Care Nurses MDS 3.0 Update	IHCA	4	$175.00
December	Cindy Sarver	Admission/Wound Care Nurse	1/20/2011	Springfield	In-Depth Training for Wound Care Nurses MDS 3.0 Update	IHCA	4	$175.00
December	Erika Dunniway	DON	12/15/2010	Hallmark House/Webinar	Bed Bugs: Don't Let Them Take a Bite Out of Your Business	LSN	4	$87.50
December	Julie Thompson	Housekeeping/Laundry Supervisor	12/15/2010	Hallmark House/Webinar	Bed Bugs: Don't Let Them Take a Bite Out of Your Business	LSN	4	$87.50
December	Lynn Brady	Administrator	12/15/2010	Hallmark House/Webinar	Helath Care Reform Outlook for Employers	LSN	4	$87.50
December	Ruth Bowen	Administravie Assistant	12/15/2010	Hallmark House/Webinar	Helath Care Reform Outlook for Employers	LSN	4	$87.50
November	Cheryl Carlson	Clinical Compliance Coordinator	12/8/2010	Springfield	The New RUGs IV - Starting Over	IHCA	4	$95.00
November	Kim Goodwin	MDS Coordinator	12/8/2010	Springfield	The New RUGs IV - Starting Over	IHCA	4	$95.00
November	Cindy Sarver	Admission/Wound Care Nurse	12/8/2010	Springfield	The New RUGs IV - Starting Over	IHCA	4	$95.00
November	Lynn Brady	Administrator	12/8/2010	Springfield	The New RUGs IV - Starting Over	IHCA	4	$95.00
Oct thru Dec	All Staff	All	1/1/10 - 12/31/10	Hallmark House/Web Training	All Mandatory Inservices	Silverchair Learning	4	$862.96
October	Lynn Brady	Administrator	10/26/2010	Springfield	Part A Live & In Person Seminar	National Government Services	4	$95.00
October	Jenny Cooper	Office Manager	10/26/2010	Springfield	Part A Live & In Person Seminar	National Government Services	4	$95.00
Septembre	Lynn Brady	Administrator	9/28/2010	Hallmark House/Webinar	Preparing for MDS 2.0 to 3.0 Transition	IHCA	4	$75.00
Septembre	Cheryl Carlson	Clinical Compliance Coordinator	9/28/2010	Hallmark House/Webinar	Preparing for MDS 2.0 to 3.0 Transition	IHCA	4	$0.00
Septembre	Jenny Cooper	Office Manager	9/28/2010	Hallmark House/Webinar	Preparing for MDS 2.0 to 3.0 Transition	IHCA	4	$0.00
Septembre	Cindy Sarver	Admission/Wound Care Nurse	9/28/2010	Hallmark House/Webinar	Preparing for MDS 2.0 to 3.0 Transition	IHCA	4	$0.00
Septembre	Kim Goodwin	MDS Coordinator	9/28/2010	Hallmark House/Webinar	Preparing for MDS 2.0 to 3.0 Transition	IHCA	4	$0.00
Septembre	Ruth Bowen	Administravie Assistant	10/8/2010	Peoria	Wage and Hour Seminar	KTG Labor Consult	4	$115.00
Septembre	All Staff	All	9/17/2010	Hallmark House	CPR Training	American Red Cross	4	$392.50
Septembre	Cindy Sarver	Admission/Wound Care Nurse	7/16/1902	Peoria	Ostomy 105	Peoria Area Ostomy Support Group	4	$20.00
August	Cheryl Carlson	Clinical Compliance Coordinator	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$495.00
August	Laurie Hill	Social Service Director	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$0.00
August	Jenny Cooper	Office Manager	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$0.00
August	Karen Knight	Activity Director	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$0.00
August	Cindy Sarver	Admission/Wound Care Nurse	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$0.00
August	Heather McCurdy	Cook	10/10 - 12/7	Hallmark House/Webinars	MDS 3.0 Section by Section Entire Series	IHCA	4	$0.00
Septembre	Debra Lang	ADON	9/22/2010	Peoria	Let's Really Look At Wheelchair Use In LTC	Culture Change Coalition of Peoria	4	$0.00
August	All Staff	All	8/24/2010	Hallmark House	CPR Training	American Red Cross	4	$410.00
July - Sept	All Staff	All	7/1/10 - 9/30/10	Hallmark House/Web Training	All Mandatory Inservices	Silverchair Learning	4	$862.96
July - Sept	Patty Halder	DON	8/11/10 - 8/12/10	Bloomington	Summer Conference	INHAA	4	$95.00
July - Sept	Laurie Hill	Social Service Director	8/11/10 - 8/12/10	Bloomington	Summer Conference	INHAA	4	$95.00
June	Heather McCurdy	Cook	6/23/2010	Springfield	MDS 3.0: Getting Ready	HCCI	4	$165.00
May	Patty Halder	DON	6/23/2010	Springfield	MDS 3.0: Getting Ready	HCCI	4	$165.00
May	Chuck Trueblood	Food Service Supervisor	6/23/2010	Springfield	MDS 3.0: Getting Ready	HCCI	4	$165.00
June	Cindy Sarver	Admission/Wound Care Nurse	6/23/2010	Springfield	MDS 3.0: Getting Ready	HCCI	4	$165.00
June	Patty Halder	DON	6/9 - 6/10/1	East Peoria	June Conference	INHAA	4	$95.00
June	Debra Lang	ADON	6/9 - 6/10/1	East Peoria	June Conference	INHAA	4	$95.00
June	Laurie Hill	Social Service Director	6/9 - 6/10/1	East Peoria	June Conference	INHAA	4	$0.00
May	Barbara Morsett	Activity Assistant	5/19/2010	Peoria	Train the Trainer	alzheimers's associa	4	$75.00
April - June	All Staff	All	4/1/10 - 6/30/10	Hallmark House/Web Training	All Mandatory Inservices	Silverchair Learning	4	$862.96
April	Laurie Hill	Social Service Director	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA	4	$165.00
April	Karen Knight	Activity Director	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA		$165.00
April	Lynn Brady	Administrator	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA	4	$165.00
April	Cheryl Carlson	Clinical Compliance Coordinator	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA	4	$165.00
April	Kim Goodwin	MDS Coordinator	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA	4	$165.00
April	Debra Lang	ADON	6/15/2010	Peoria	MDS 3.0: Getting Started	IHCA	4	$165.00
April	Ruth Bowen	Administrative Assistant	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Kevin Dickerson	Maintenance Director	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Jerry Bissell	Maintenance Assistant	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Barbara Morsett	Activity Assistant	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Bobbi Cosgrove	Activity Assistant	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Jaclyn Logue	Activity Assistant	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
April	Jenny Cooper	Office Manager	4/3/2010	Hallmark House	Medicar Safety Training	Medicarsafety.com,	4	$1,000.00
March	Debra Lang	ADON	4/28/2010	Springfield	An Overview of the Quality Indicator Survey	IHCA	4	$90.00
March	Cindy Sarver	Admission/Wound Care Nurse	4/28/2010	Springfield	An Overview of the Quality Indicator Survey	IHCA	4	$90.00
March	Julie Thompson	Housekeeping/Laundry Supervisor	4/28/2010	Springfield	An Overview of the Quality Indicator Survey	IHCA	4	$90.00
March	Lynn Brady	Administrator	4/28/2010	Springfield	An Overview of the Quality Indicator Survey	IHCA	4	$90.00
March	Kevin Dickerson	Maintenance Director	5/11/2011	Springfield	The Most Frequent Life Safety Code Violation	IHCA	4	$75.00
March	Cindi Hueser	DON	3/17-3/18/2	East Peoria	Winter Conference	INHAA	4	$95.00
March	Kevin Dickerson	Maintenance Director	3/17-3/18/2	East Peoria	Winter Conference	INHAA	4	$95.00
Jan - March	All Staff	All	1/1/10 - 3/31/10	Hallmark House/Web Training	All Mandatory Inservices	Silverchair Learning	4	$862.96
January	Debra Lang	ADON	2/25/2010	Springfield	F323 Accident & Fall Prevention Strategies	IHCA	4	$95.00
January	Kevin Dickerson	Maintenance Director	2/25/2010	Springfield	F323 Accident & Fall Prevention Strategies	IHCA	4	$95.00
January	Ruth Bowen	Administrative Assistant	2/2/2010	Hallmark House/Webinars	What You Need to Know About the Sweeping Changes to HPAA Privacy	IHCA	4	$75.00
	TOTAL							$16,224.34

Group Classification: (1) Out-of-State Travel, (2) In-State Travel, (3) Seminar Expense, (4) Education and Seminars, (5) Administr

Hallmark House
Support Schedules
For the Year Ended December 31, 2010

Illinois Medicaid Cost Report
Page 19., Line 28a Other Revenue

Recycling Revenue	123	
Soda Income	5,442	(1)
Avon Income	4,360	(1)
Vending Machine Revenue	2,311	(1)
Late Fee Income	53	
	$ 12,289	

(1) See page 5, expenses related to this revenue was adjusted on page 5.