FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Ctr

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

County: Tazewell

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

HFS ID Number:

Date of Initial License for Current Owners: 5/1/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	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:** 618-315-6242
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 1/1/15 to 12/31/15 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 Preparation Report (Date)
(Print Name and Title) Margel S. Peddicord, CPA
(Firm Name & Address) Margel S. Peddicord, CPA, 2616 Windcrest Dr., Mt. Vernon, IL 62864
(Telephone) 618-315-6242 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 Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	7,110	7,630	3,739	18,479	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,110	7,630	3,739	18,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.31%

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 12/20/80

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

YES [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 3,649

Medicare Intermediary Ability

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	160,739	18,561	11,684	190,984		190,984		190,984			1
2	Food Purchase		113,722		113,722	2,196	115,918	(3,109)	112,809			2
3	Housekeeping	107,989	17,254		125,243		125,243		125,243			3
4	Laundry	29,575	9,162	966	39,703		39,703		39,703			4
5	Heat and Other Utilities			92,850	92,850		92,850		92,850			5
6	Maintenance	71,123	5,925	30,938	107,986		107,986	25,657	133,643			6
7	Other (specify):*											7
8	**TOTAL General Services**	369,426	164,624	136,438	670,488	2,196	672,684	22,548	695,232			8
	B. Health Care and Programs											
9	Medical Director			23,500	23,500		23,500		23,500			9
10	Nursing and Medical Records	1,299,695	92,175	34,225	1,426,095		1,426,095		1,426,095			10
10a	Therapy		669	420,205	420,874		420,874		420,874			10a
11	Activities	46,630	1,237	5,972	53,839		53,839		53,839			11
12	Social Services	44,517	4	4,909	49,430		49,430		49,430			12
13	CNA Training											13
14	Program Transportation			3,950	3,950		3,950		3,950			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,390,842	94,085	492,761	1,977,688		1,977,688		1,977,688			16
	C. General Administration											
17	Administrative	80,425		96,000	176,425		176,425	(96,000)	80,425			17
18	Directors Fees											18
19	Professional Services			32,505	32,505		32,505	1,900	34,405			19
20	Dues, Fees, Subscriptions & Promotions			21,358	21,358	(2,196)	19,162	(12,605)	6,557			20
21	Clerical & General Office Expenses	86,153	4,840	95,939	186,932		186,932	(1,761)	185,171			21
22	Employee Benefits & Payroll Taxes			326,788	326,788		326,788		326,788			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,037	4,037		4,037		4,037			24
25	Other Admin. Staff Transportation			4,894	4,894		4,894		4,894			25
26	Insurance-Prop.Liab.Malpractice			21,759	21,759		21,759		21,759			26
27	Other (specify):*			22,522	22,522		22,522	(22,522)				27
28	**TOTAL General Administration**	166,578	4,840	625,802	797,220	(2,196)	795,024	(130,988)	664,036			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,926,846	263,549	1,255,001	3,445,396		3,445,396	(108,440)	3,336,956			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: 1/1/15 Ending: 12/31/15

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			51,172	51,172		51,172	68,707	119,879			30
31	Amortization of Pre-Op. & Org.							2,003	2,003			31
32	Interest			5,907	5,907		5,907	37,889	43,796			32
33	Real Estate Taxes			27,576	27,576		27,576	7,978	35,554			33
34	Rent-Facility & Grounds			279,281	279,281		279,281	(279,281)				34
35	Rent-Equipment & Vehicles			18,563	18,563		18,563		18,563			35
36	Other (specify):*											36
37	**TOTAL Ownership**			382,499	382,499		382,499	(162,704)	219,795			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			190,741	190,741		190,741		190,741			39
40	Barber and Beauty Shops	35,177	304	28	35,509		35,509		35,509			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,971	133,971		133,971		133,971			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	35,177	304	324,740	360,221		360,221		360,221			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,962,023	263,853	1,962,240	4,188,116		4,188,116	(271,144)	3,916,972			45

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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				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				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	(22,522)	27		24
25	Fund Raising, Advertising and Promotional	(12,605)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see attached page 5a	(44,211)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,338)		$	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)	(191,806)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (191,806)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (271,144)		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 Ctr

ID# 0036343

Report Period Beginning: 1/1/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust accrual of real estate tax	$ 7,978	33	1
2	Depreciation expense	48,681	30	2
3	To remove mgt fee	(96,000)	17	3
4	To offset rebate and refund income	(3,109)	2	4
5	To offset rebate and refund income	(1,761)	21	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
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**	(44,211)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,109)	0	0	0	0	0	0	0	0	0	0	(3,109)	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	25,657	0	0	0	0	0	0	0	0	0	25,657	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,109)	25,657	0	0	0	0	0	0	0	0	0	22,548	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	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(96,000)	0	0	0	0	0	0	0	0	0	0	(96,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,900	0	0	0	0	0	0	0	0	0	1,900	19
20	Fees, Subscriptions & Promotions	(12,605)	0	0	0	0	0	0	0	0	0	0	(12,605)	20
21	Clerical & General Office Expenses	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	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):*	(22,522)	0	0	0	0	0	0	0	0	0	0	(22,522)	27
28	**TOTAL General Administration**	(132,888)	1,900	0	0	0	0	0	0	0	0	0	(130,988)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,997)	27,557	0	0	0	0	0	0	0	0	0	(108,440)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Hallmark House Nursing Ctr** **#** **0036343** **Report Period Beginning:** **1/1/15** **Ending:** **12/31/15**

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	48,681	20,026	0	0	0	0	0	0	0	0	0	68,707	30
31	Amortization of Pre-Op. & Org.	0	2,003	0	0	0	0	0	0	0	0	0	2,003	31
32	Interest	0	37,889	0	0	0	0	0	0	0	0	0	37,889	32
33	Real Estate Taxes	7,978	0	0	0	0	0	0	0	0	0	0	7,978	33
34	Rent-Facility & Grounds	0	(279,281)	0	0	0	0	0	0	0	0	0	(279,281)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	56,659	(219,363)	0	0	0	0	0	0	0	0	0	(162,704)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,338)	(191,806)	0	0	0	0	0	0	0	0	0	(271,144)	45

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 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	$ 279,281			$	$ (279,281)	1
2	V	19	Professional fees		Pekin Professional Group		1,900	1,900	2
3	V	32	Interest		Pekin Professional Group		37,889	37,889	3
4	V	30	Depreciation		Pekin Professional Group		20,026	20,026	4
5	V	31	Amortization		Pekin Professional Group		2,003	2,003	5
6	V	6	Repairs		Pekin Professional Group		25,657	25,657	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 279,281			$ 87,475	$ * (191,806)	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: 1/1/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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19								19
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25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	NA								$		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: 1/1/15 Ending: 12/31/15

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		NA				$	$		$	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: 1/1/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1			x	Mortgage			$	$			$ 37,889	1
2												2
3												3
4												4
5												5
	Working Capital											
6				Operating							5,907	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 43,796	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 43,796	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 Ctr # 0036343 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	34,072	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.)	$	34,813	2
3. Under or (over) accrual (line 2 minus line 1).	$	741	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,813	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.	$	35,554	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	33,903	8
2011	31,490	9
2012	34,110	10
2013	34,072	11
2014	34,813	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Ctr COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Margel S. Peddicord, CPA

TELEPHONE 618-315-6242 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-10-01-407-018	LTC Facility	$ 34,813.00	$ 34,813.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,813.00	$ 34,813.00

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 [ ] (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).

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	LTC facility	292,455	1980	$ 57,000	1
2					2
3	TOTALS	292,455		$ 57,000	3

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	$ 370,293	4
5											5
6			1980	1976	290,586	32,796	40	7,265	(25,531)	228,957	6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1977	41,421		20	1,035	1,035	31,056	9
10	Building Improvements			1978	6,473		20			6,473	10
11	Building Improvements			1981	10,987		20	275	275	8,246	11
12	Building Improvements			1982	12,368		20	309	309	9,273	12
13	Building Improvements			1983	7,662		20	191	191	5,735	13
14	Building Improvements			1984	2,343		20	58	58	1,744	14
15	Building Improvements			1986	17,604		20	482	482	14,152	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			15,387	18
19	Building Improvements			1990	55,198		20	1,464	1,464	36,600	19
20	Building Improvements			1991	11,136		20			11,856	20
21	Building Improvements			1993	53,652		20	528	528	23,319	21
22	Building Improvements			1994	45,374		20			45,374	22
23	Building Improvements			1995	110,087		20	4,438	4,438	93,046	23
24	Building Improvements			1996	26,910		20	450	450	19,776	24
25	Building Improvements			1997	43,197		20			43,197	25
26	Building Improvements			1998	118,189		20	5,994	5,994	104,896	26
27	Building Improvements			1999	29,258		20	897	897	25,583	27
28	Building Improvements			2000	253,531		20	9,642	9,642	160,341	28
29	Building Improvements			2001	21,498		20	1,312	1,312	19,680	29
30				2002	22,175		20			22,815	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 Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 1,456	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	2,561	38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20	68	68	887	39
40	Griddle Exhaust	2003	2,076		20	104	104	1,559	40
41	Circuits & Outlets	2003	2,926		20	146	146	1,900	41
42	Heater in room 116	2003	1,100		20	55	55	715	42
43	Kitchen Remodel	2003	5,967		20	298	298	3,876	43
44	Blinds	2003	833		20	42	42	544	44
45	Boiler Pump	2003	1,694		20	85	85	1,075	45
46	Boiler Repair	2003	2,247		20	112	112	1,384	46
47	Glass Doors	2003	1,602		20	80	80	960	47
48	Boiler	2003	1,154		20	58	58	598	48
49	Lighting	2004	610		20	31	31	370	49
50	Blinds, Valance	2004	8,175		20	409	409	5,143	50
51	Light Fixture	2004	759		20	38	38	456	51
52	Blinds & vallance	2004	9,773		20	489	489	6,100	52
53	Boiler	2004	4,586		20	229	229	2,750	53
54	Outside lighting	2004	3,155		20	158	158	1,895	54
55	Roof	2004	4,419		20	221	221	2,652	55
56	Bathroom remodel	2004	1,054		20	53	53	634	56
57	Cabinets & countertop	2004	890		20	45	45	538	57
58	Bathroom flooring	2004	546		20	27	27	326	58
59	Air conditioner	2004	3,278		20	164	164	1,968	59
60	Bathroom remodel	2004	2,000		20	100	100	1,200	60
61	Cabinets & countertop	2004	460		20	23	23	276	61
62	Cabinets in beverage centger	2004	250		20	13	13	154	62
63	Houthous	2004	7,929		20	396	396	4,754	63
64	Fire Door	2004	879		20	44	44	528	64
65	Hot water heater	2004	650		20	33	33	394	65
66	Tub repairs	2004	539		20	27	27	324	66
67	Tub repairs	2004	500		20	25	25	233	67
68	Door locks	2004	985		20	49	49	590	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,834,235	$ 45,784		$ 51,032	$ 5,248	$ 1,396,785	70

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 45,784		$ 51,032	$ 5,248	$ 1,396,785	1
2	Exhaust fan repairs	2004	717		20	36	36	432	2
3	Water heater repairs	2004	720		20	36	36	432	3
4	Plumbing repairs	2004	5,620		20	281	281	3,372	4
5	Garbage Disposals	2004	850		20	43	43	514	5
6	Storage room remodel	2004	696		20	35	35	419	6
7	Room Remodel	2004	4,496		20	225	225	2,699	7
8	Back sidewalk	2005	1,600		20	80	80	880	8
9	Fire door	2005	487		20	24	24	266	9
10	Front sidewalk	2005	1,700		20	85	85	935	10
11	Fire Dampers.	2005	747		20	37	37	409	11
12	Irrigation System	2005	7,750		20	388	388	4,266	12
13	Landscaping	2005	942		20	47	47	517	13
14	Landscaping	2005	6,028		20	301	301	3,310	14
15	Fish pond	2005	5,027		20	251	251	2,763	15
16	Office floor	2005	319		20	16	16	176	16
17	Walk in cooler floor	2005	800		20	40	40	440	17
18	Walk in freezer floor	2005	540		20	27	27	350	18
19	Water system pump	2005	852		20	43	43	471	19
20	Breaker panel replacement	2005	1,952		20	98	98	1,076	20
21	Public bath tile	2005	219		20	11	11	121	21
22	Wire fish pond	2005	1,016		20	51	51	561	22
23	Detectors	2005	860		20	43	43	473	23
24	Gutters	2005	2,375		20	119	119	1,309	24
25	Mixing valve	2005	714		20	36	36	394	25
26	Blacktop repair	2005	1,846		20	92	92	1,013	26
27	Blacktop repair	2005	320		20	16	16	176	27
28	Wire outside lights	2006	1,145		20	57	57	571	28
29	Plywood for Air lock ceiling	2006	123		20	6	6	60	29
30	Install entry for air lock	2006	3,935		20	197	197	1,970	30
31	Door for air lock	2006	3,028		20	151	151	1,511	31
32	Dining outlet	2006	155		20	8	8	80	32
33	Exhaust fan & rewire junction	2006	1,633		20	82	82	819	33
34	TOTAL (lines 1 thru 33)		$ 1,893,447	$ 45,784		$ 53,994	$ 8,210	$ 1,429,570	34

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 45,784		$ 53,994	$ 8,210	$ 1,429,570	1
2	Outlet for steamer in kitchen	2006	381		20	19	19	190	2
3	Remodeol bathroom 129	2006	508		20	25	25	251	3
4	Cabinets for bath in Rm 129	2006	946		20	47	47	471	4
5	Install sink in janitor closet	2006	1,500		20	75	75	750	5
6	Plumbing for bathroom	2006	1,350		20	68	68	679	6
7	Cabinets for bath	2006	443		20	22	22	220	7
8	Replace flooring in rm 129 bath	2006	370		20	19	19	189	8
9	New door nurses station	2006	1,314		20	66	66	659	9
10	Reroof east end	2006	4,928		20	246	246	2,461	10
11	Flooring shower room	2006	1,565		20	78	78	781	11
12	Ada door opener downpay	2006	512		20	26	26	259	12
13	Ada door opener	2006	1,536		20	77	77	770	13
14	New activity room door	2006	1,710		20	86	86	859	14
15	New carpeting	2006	11,500		20	575	575	5,750	15
16	Tile bathroom remodel	2006	371		20	19	19	189	16
17	Sidewalk	2006	243		20	12	12	120	17
18	Sidewalk in front	2006	757		20	38	38	380	18
19	Bathroonm flooring Rm 114	2006	465		20	23	23	231	19
20	Cabinets for bathroom	2006	1,168		20	58	58	581	20
21	Bathroom remoded rm 114	2006	350		20	18	18	179	21
22	Plywood reroof east end	2006	1,689		20	84	84	841	22
23	Carpeting	2006	11,500		20	575	575	5,750	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	920	24
25	Doors	2007	6,052		20	303	303	2,726	25
26	Carpeting	2007	11,000		20	550	550	4,950	26
27	Tile work	2007	2,930		20	147	147	1,322	27
28	Hood systems to alarm	2007	1,836		20	92	92	828	28
29	Electrical work	2007	2,961		20	148	148	1,332	29
30	Vent air conditioner hall	2007	1,140		20	57	57	513	30
31	Folding doors	2007	4,236		20	212	212	1,908	31
32	AC Dining room	2007	5,800		20	290	290	2,610	32
33	Bathroom	2007	15,450			773	773	6,956	33
34	TOTAL (lines 1 thru 33)		$ 1,991,801	$ 45,784		$ 58,914	$ 13,130	$ 1,476,195	34

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 45,784		$ 58,914	$ 13,130	$ 1,476,195	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20	1,486	1,486	11,888	2
3	Plumbing return line	2008	2,875		20	144	144	1,152	3
4	Boiler	2008	5,631		20	282	282	2,256	4
5	AC basement office	2008	452		20	23	23	184	5
6	SPA tile	2008	3,530		20	177	177	1,416	6
7	Walk in	2008	29,462		20	1,473	1,473	11,784	7
8	Heat pkg dining room	2008	301		20	15	15	120	8
9	Install fans in kitchen	2008	1,650		20	83	83	664	9
10	Install grease trap	2008	1,894		20	95	95	760	10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20	436	436	3,052	11
12	Lighting	2010	12,987		40	325	325	1,652	12
13	Generator	2010	48,199		10	4,820	4,820	26,108	13
14	Kitchen air conditioner	2011	14,198		40	355	355	1,657	14
15	Heating unit	2011	3,783		40	95	95	419	15
16	Tankless water heaters (2)	2011	6,500		10	650	650	2,817	16
17	Roof over dining room	2011	17,885		40	447	447	2,198	17
18	Doors for Gazebo entrance	2011	5,018		40	125	125	605	18
19	Hallway lighting	2011	3,575		40	89	89	423	19
20	Therapy door	2011	4,470		40	112	112	523	20
21	Expansion joints repair	2011	2,806		40	70	70	303	21
22	Roof on Admin . Bldg.	2012	15,456		20	773	773	4,638	22
23	Sidewalks in front of facility	2012	8,850		20	443	443	2,656	23
24	Boiler	2012	16,885		20	844	844	5,066	24
25	Parking lot expansion	2013	49,995		20	2,500	2,500	6,250	25
26	Dining room remodel	2013	5,689		40	142	142	355	26
27	Fire system upgrade	2013	6,347		10	635	635	1,587	27
28	Air Conditioner Unit	2015	8,860		39	114	114	114	28
29	Indoor/OH Sprinkler System	2015	8,520		39	109	109	109	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,316,064	$ 45,784		$ 75,776	$ 29,992	$ 1,566,951	34

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 318,108	$	$ 32,596	$ 32,596		$ 164,226	71
72	Current Year Purchases	62,128		7,261	7,261		7,261	72
73	Fully Depreciated Assets	582,461					582,461	73
74								74
75	TOTALS	$ 962,697	$	$ 39,857	$ 39,857		$ 753,948	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Ford Van	1996	$ 35,576	$	$	$		$ 35,576	76
77	Facility	2007 Chevy HHR	2007	18,012					18,012	77
78	Facility	2015 Ford Explorer	2015	42,459	5,388	4,246	(1,142)	5	4,246	78
79										79
80	TOTALS			$ 96,047	$ 5,388	$ 4,246	$ (1,142)		$ 57,834	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)	$ 3,431,808	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,172	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 119,879	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68,707	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,378,733	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: 1/1/15 Ending: 12/31/15

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

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 18,563 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 Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	10a-3	hrs	$ 192,923		$	$		$ 192,923	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs	18,777					18,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs	208,505					208,505	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts	190,741					190,741	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 610,946		$	$		$ 610,946	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.

STATE OF ILLINOIS

Facility Name & ID Number Hallmark House Nursing Ctr **#** 0036343 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 559,123	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	847,466		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	29,430		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	68,868		7
8	Accounts Receivable (owners or related parties)	6,234		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,511,121	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	889,367		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,058,748		16
17	Accumulated Depreciation (book methods)	(1,454,646)		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)**	$ 493,468	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,004,589	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,381	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	35,726		29
30	Accrued Salaries Payable	132,273		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,604		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37		96,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 426,983	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,456		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)**	$ 36,456	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 463,440	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,541,149	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,004,589	$	48

***(See instructions.)**

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,971,724	1
2	Restatements (describe):		2
3	**Correction**	20,202	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,991,926	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,223	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	(600,000)	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)**	$ (450,777)	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)**	$ 1,541,149	24 *

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,027,095	1
2	Discounts and Allowances for all Levels	(2,357,699)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,669,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	645,692	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 645,692	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	12,233	13
14	Non-Patient Meals	4,187	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	45,425	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,160	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,006	23
	D. Non-Operating Revenue		
24	Contributions	105	24
25	Interest and Other Investment Income***	134	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 239	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Rebates and refunds see adjustments**	4,870	28
28a	**Miscellaneous**	262	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,132	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,390,465	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	670,488	31
32	Health Care	1,977,688	32
33	General Administration	797,220	33
	B. Capital Expense		
34	Ownership	382,499	34
	C. Ancillary Expense		
35	Special Cost Centers	226,250	35
36	Provider Participation Fee	133,971	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,188,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	202,349	41
42	**Income Taxes**	(53,126)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 149,223	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 962,490	44
45	Private Pay - Net Inpatient Revenue	1,298,612	45
46	Medicare - Net Inpatient Revenue	1,408,294	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,669,396	49

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

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

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	2,034	2,080	$ 63,833	$ 30.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,166	9,443	230,887	24.45	3
4	Licensed Practical Nurses	12,584	13,023	278,567	21.39	4
5	CNAs & Orderlies	47,305	48,605	532,176	10.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,801	2,080	28,734	13.81	9
10	Activity Assistants	3,324	3,352	47,317	14.12	10
11	Social Service Workers	2,228	2,080	41,855	20.12	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,080	47,112	22.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,398	9,969	167,408	16.79	15
16	Dishwashers					16
17	Maintenance Workers	2,043	2,080	50,884	24.46	17
18	Housekeepers	9,606	9,800	80,861	8.25	18
19	Laundry	2,628	2,640	21,883	8.29	19
20	Administrator	2,036	2,080	85,000	40.87	20
21	Assistant Administrator	408	448	5,962	13.31	21
22	Other Administrative	1,675	1,771	32,776	18.51	22
23	Office Manager	1,004	1,072	22,457	20.95	23
24	Clerical	1,675	1,715	17,393	10.14	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	1,970	2,080	29,037	13.96	31
32	Other Health C: Other Nursing	9,503	9,827	152,311	15.50	32
33	Other(specify) Cosmetologist	1,533	1,669	25,570	15.32	33
34	TOTAL (lines 1 - 33)	123,977	127,894	$ 1,962,023 *	$ 15.34	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		$ 6,248	1-3	35
36	Medical Director		23,500	9-3	36
37	Medical Records Consultant		1,960	10-3	37
38	Nurse Consultant		3,792	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,596	11-3	44
45	Social Service Consultant		1,596	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,692		49

C. CONTRACT NURSES

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Read	Administrator	0	$ 80,425
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,425

B. Administrative - Other

Description	Amount
Mgt Fee -- See Adjustment	$ 96,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 96,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Michael T. Mahoney	Legal fees	$ 140
Elias, Meginnes & Seghetti	Legal fees	755
RSM US LLP	Accounting fees	23,860
Hawkes & Hastings	Accounting fees	2,300
Plante and Moran	Accounting fees	2,450
Margel S. Peddicord, CPA	Accounting fees	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 32,505

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,218
Unemployment Compensation Insurance	37,276
FICA Taxes	203,095
Employee Health Insurance	40,962
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee physicals	8,727
Employee uniforms	1,871
Employee life insurance	639
TOTAL (agree to Schedule V, line 22, col.8)	$ 326,788

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	$
Advertising: Employee Recruitment	2,483
Health Care Worker Background Check	1,624
(Indicate # of checks performed)	
Patient Background Checks	
Applicaation fee	75
See Attachment	1,799
INHAA Membership	100
AMEX member fees	476
Marketing	12,605
Less: Public Relations Expense	( )
Non-allowable advertising	(12,605)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,557

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,037
See Attachment #2	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,037

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	NA		$		$	$	$	$	$	$	$	$	$
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 Ctr # 0036343 Report Period Beginning: 1/1/15 Ending: 12/31/15

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. **INHAA $100**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,160** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **133,971**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NA** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **NA**
c. What percent of all travel expense relates to transportation of nurses and patients? **NA**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
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. $ **NA**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **NA**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NA**
Attach invoices and a summary of services for all architect and appraisal fees

Hallmark House, Pekin, IL
Medicaid Cost Report 12/31/15
Attachments

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Pekin Chamber of Commerce Membership	$	500
AANAC		110
SNFCB consolidated billing		450
MES of IL HPSI		175
HSC Act Dir Course		495
Notary fees		69
Total	$	1,799

Hallmark House
Support Schedules - Travel and Seminar
For the Year Ended December 31, 2014

Month of Service	Name of Individual Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Classification	Cost
Mar-14	Katie Henderson	Care Plan Coordinator	3/18, 3/19, 3/20	Springfield, IL	Resident Services Coordinator Certification	AANAC	4	$750.00
Mar-14	Cheryl Carlson	MDS Coordinator	3/18, 3/19, 3/20	Springfield, IL	Resident Services Coordinator Certification	AANAC	4	$750.00
Mar-14	Rachel Grace	Activity Director	3/4, 3/5	Champaign, IL	Activity Director Course	Health Service Consultants	4	$495.00
Mar-15	Tiffany Vaughn	Restorative Nurse	3/3-3/7	East Peoria, IL	Restorative Certification	Pathway Health	4	$899.00
May-14	Laurie Read	Administrator	5/1	Bloomington, IL	Medication Reduction	Continuing Education of IL	5	$116.10
May-15	Laurie Hill	Social Service Dir.	5/1	Bloomington, IL	Medication Reduction	Continuing Education of IL	5	$116.10
May-15	Tiffany Vaughn	Restorative Nurse	5/1	Bloomington, IL	Medication Reduction	Continuing Education of IL	5	$116.10
Sep-14	Chuck Trueblood	Dietary Manager	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Cheryl Carlson	MDS Coordinator	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Laurie Warren	DON	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Laurie Read	Administrator	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Troy Jensen	Maintence Director	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Laurie Hill	Social Service Dir.	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Rachel Grace	Activity Director	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Katie Henderson	Care Plan Coordinato	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Tiffany Vaughn	Restorative Nurse	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	BJ Hale	Housekeeping Sup.	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.27
Sep-14	Heather Fischer	Office Assistant	9/8-9/11	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.	4	$72.30
						TOTAL		$4,037.30