FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0036343

Facility Name: Hallmark House Nursing Ctr

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: 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: Chris Joos **Telephone Number:** 614.222.9040
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 1/1/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Chris Joos, Partner
(Firm Name & Address) Plante Moran, PLLC, 250 South High Street, Suite 100
(Telephone) 614.222.9040 Fax # 248.233.8811

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: 1/1/17 Ending: 12/31/17

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	71.00	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	4,430	5,563	5,512	15,505	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,430	5,563	5,512	15,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.83%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 12/20/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/20/1980 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 2,599

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	141,665	13,499	5,110	160,274		160,274		160,274			1
2	Food Purchase		91,617		91,617		91,617		91,617			2
3	Housekeeping	62,851	20,288		83,139		83,139		83,139			3
4	Laundry	86,753	7,535		94,288		94,288		94,288			4
5	Heat and Other Utilities			73,832	73,832		73,832		73,832			5
6	Maintenance	56,098	53,380		109,478		109,478		109,478			6
7	Other (specify):* TRASH/SECURITY			14,908	14,908		14,908		14,908			7
8	TOTAL General Services	347,367	186,319	93,850	627,536		627,536		627,536			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,206,573	81,248	5,666	1,293,487		1,293,487		1,293,487			10
10a	Therapy			454,885	454,885		454,885		454,885			10a
11	Activities	56,642	140	1,428	58,210		58,210		58,210			11
12	Social Services	71,473		1,428	72,901		72,901		72,901			12
13	CNA Training											13
14	Program Transportation			2,109	2,109		2,109		2,109			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,334,688	81,388	486,516	1,902,592		1,902,592		1,902,592			16
	C. General Administration											
17	Administrative	124,427			124,427		124,427		124,427			17
18	Directors Fees											18
19	Professional Services			88,530	88,530		88,530		88,530			19
20	Dues, Fees, Subscriptions & Promotions			11,994	11,994		11,994		11,994			20
21	Clerical & General Office Expenses	48,323	28,395	672	77,390		77,390	7,102	84,492			21
22	Employee Benefits & Payroll Taxes			378,362	378,362		378,362		378,362			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,748	2,748		2,748		2,748			24
25	Other Admin. Staff Transportation			435	435		435		435			25
26	Insurance-Prop.Liab.Malpractice			92,589	92,589		92,589		92,589			26
27	Other (specify):* MARKETING			9,433	9,433		9,433	(9,433)				27
28	TOTAL General Administration	172,750	28,395	584,763	785,908		785,908	(2,331)	783,577			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,854,805	296,102	1,165,129	3,316,036		3,316,036	(2,331)	3,313,705			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:** 1/1/17 **Ending:** 12/31/17

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			71,517	71,517		71,517		71,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,404	8,404		8,404		8,404			32
33	Real Estate Taxes			36,103	36,103		36,103		36,103			33
34	Rent-Facility & Grounds			288,184	288,184		288,184		288,184			34
35	Rent-Equipment & Vehicles			10,043	10,043		10,043		10,043			35
36	Other (specify):* TAXES			6,918	6,918		6,918	(6,918)				36
37	**TOTAL Ownership**			421,169	421,169		421,169	(6,918)	414,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91	118,842	118,933		118,933		118,933			39
40	Barber and Beauty Shops	11,913		406	12,319		12,319		12,319			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,817	112,817		112,817		112,817			42
43	Other (specify):* NON-REIMBURS/			1,476	1,476		1,476	(1,476)				43
44	**TOTAL Special Cost Centers**	11,913	91	233,541	245,545		245,545	(1,476)	244,069			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,866,718	296,193	1,819,839	3,982,750		3,982,750	(10,725)	3,972,025			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: 1/1/17 Ending: 12/31/17

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		2		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		32		10
11	Discounts, Allowances, Rebates & Refunds		21		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	(2,319)	21		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	9,421	21		24
25	Fund Raising, Advertising and Promotional	(9,433)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,918)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,476)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,725)		$	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)		VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,725)		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: 1/1/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing)	0	22	2
3	Other Non-Reimburseable costs	(1,476)	43	3
4		0		4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(1,476)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	7,102	0	0	0	0	0	0	0	0	0	0	7,102	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):*	(9,433)	0	0	0	0	0	0	0	0	0	0	(9,433)	27
28	**TOTAL General Administration**	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Hallmark House Nursing Ctr** **#** **0036343** **Report Period Beginning:** **1/1/17** **Ending:** **12/31/17**

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	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**(6,918)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(6,918)**	**36**
37	**TOTAL Ownership**	**(6,918)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(6,918)**	**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):*	**(1,476)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,476)**	**43**
44	**TOTAL Special Cost Centers**	**(1,476)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,476)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(10,725)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(10,725)**	**45**

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 [X] 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		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	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: 1/1/17 Ending: 12/31/17

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	N/A							2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 [X]

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		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	NOTE PAYABLE BUSEY		X	WORKING CAPITAL LOC				195,625			8,404	6
7												7
8												8
9	TOTAL Facility Related						$	$ 195,625			$ 8,404	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 195,625			$ 8,404	15

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

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 **Report Period Beginning:** 1/1/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 35,111	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.)		$ 35,834	2
3. Under or (over) accrual (line 2 minus line 1).		$ 723	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 35,380	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.		$ 36,103	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	34,110	8
	2013	34,072	9
	2014	34,813	10
	2015	35,111	11
	2016	35,834	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Ctr COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Chris Joos

TELEPHONE 614.222.9040 FAX #: 248.233.8811

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-10-01-407-018	LTC FACILITY	$ 35,833.92	$ 35,833.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,833.92	$ 35,833.92

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/17 Ending: 12/31/17

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: 1/1/17 Ending: 12/31/17

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	$		$	$	$	4
5			1980	1976	290,586						5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1977	41,421						9
10	Building Improvements			1978	6,473						10
11	Building Improvements			1981	10,987						11
12	Building Improvements			1982	12,368						12
13	Building Improvements			1983	7,662						13
14	Building Improvements			1984	2,343						14
15	Building Improvements			1986	17,604						15
16	Building Improvements			1987	7,275						16
17	Building Improvements			1988	42,911						17
18	Building Improvements			1989	15,387						18
19	Building Improvements			1990	55,198						19
20	Building Improvements			1991	11,136						20
21	Building Improvements			1993	53,652						21
22	Building Improvements			1994	45,374						22
23	Building Improvements			1995	110,087						23
24	Building Improvements			1996	26,910						24
25	Building Improvements			1997	43,197						25
26	Building Improvements			1998	118,189						26
27	Building Improvements			1999	29,258						27
28	Building Improvements			2000	253,531						28
29	Building Improvements			2001	21,498						29
30	Building Improvements			2002	22,175						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: 1/1/17 Ending: 12/31/17

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$		$	$	$	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20				2
3	Plumbing return line	2008	2,875		20				3
4	Boiler	2008	5,631		20				4
5	AC basement office	2008	452		20				5
6	SPA tile	2008	3,530		20				6
7	Walk in	2008	29,462		20				7
8	Heat pkg dining room	2008	301		20				8
9	Install fans in kitchen	2008	1,650		20				9
10	Install grease trap	2008	1,894		20				10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20				11
12	Lighting	2010	12,987		40				12
13	Generator	2010	48,199		10				13
14	Kitchen air conditioner	2011	14,198		40				14
15	Heating unit	2011	3,783		40				15
16	Tankless water heaters (2)	2011	6,500		10				16
17	Roof over dining room	2011	17,885		40				17
18	Doors for Gazebo entrance	2011	5,018		40				18
19	Hallway lighting	2011	3,575		40				19
20	Therapy door	2011	4,470		40				20
21	Expansion joints repair	2011	2,806		40				21
22	Roof on Admin . Bldg.	2012	15,456		20				22
23	Sidewalks in front of facility	2012	8,850		20				23
24	Boiler	2012	16,885		20				24
25	Parking lot expansion	2013	49,995		20				25
26	Dining room remodel	2013	5,689		40				26
27	Fire system upgrade	2013	6,347		10				27
28	Air Conditioner Unit	2015	8,860		39				28
29	Indoor/OH Sprinkler System	2015	8,520		39				29
30									30
31									31
32	As Per Pekin Investment Group, LLC			36,712		36,712		943,574	32
33	As Per Hallmark House Nursing Center			17,671		17,671		685,499	33
34	TOTAL (lines 1 thru 33)		$ 2,316,064	$ 54,383		$ 54,383	$	$ 1,629,073	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: 1/1/17 Ending: 12/31/17

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	$ 380,236	$ 35,095	$ 35,095	$	Various	$ 230,662	71
72	Current Year Purchases	6,447	820	820		Various	820	72
73	Fully Depreciated Assets	582,461				Various	582,461	73
74								74
75	TOTALS	$ 969,144	$ 35,915	$ 35,915	$		$ 813,943	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Van 2016	2016	$ 47,195	$ 9,439	$ 9,439	$	5	$ 14,159	76
77	Facility	2007 Chevy HHR	2007	18,012				5	18,012	77
78	Facility	2015 Ford Explorer	2015	42,459	8,492	8,492		5	24,768	78
79										79
80	TOTALS			$ 107,666	$ 17,931	$ 17,931	$		$ 56,939	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)	$ 3,449,874	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,229	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 108,229	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,499,955	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: 1/1/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1980	71	5/1/90	$ 288,184	5	20	3
4	Additions							4
5								5
6								6
7	TOTAL		71		$ 288,184 **			7

10. Effective dates of current rental agreement:
Beginning 3/31/16
Ending 3/31/21

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

	Fiscal Year Ending	Annual Rent
12.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: [ ] YES [X] 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: $ 10,043 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: 1/1/17 Ending: 12/31/17

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.

STATE OF ILLINOIS

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	0.00	hrs	$ 0	4,829	$ 211,898	$ 0	4,829	$ 211,898	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	409	15,747	0	409	15,747	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	3,976	227,240	0	3,976	227,240	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	0.00	hrs	0	0	0	0			8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	96,269		96,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	22,573		22,573	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	91		91	13
14	TOTAL				$	9,214	$ 454,885	$ 118,933	9,214	$ 573,818	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:** 1/1/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 705,491	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	327,497		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,276		6
7	Other Prepaid Expenses	690		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)**	$ 1,111,188	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	208,932		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	907,606		15
16	Equipment, at Historical Cost	1,076,813		16
17	Accumulated Depreciation (book methods)	(1,556,380)		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)**	$ 636,971	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,748,159	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 142,049	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,482		30
31	Accrued Taxes Payable (excluding real estate taxes)	(479,028)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,704		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	505,440		35
	Other Current Liabilities(specify):			
36				36
37		11,741		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 277,388	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	195,625		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)**	$ 195,625	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 473,013	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,275,146	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,748,159	$	48

***(See instructions.)**

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,559,997	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,559,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(287,590)	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	(7,935)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY ADJUSTMENT**	10,674	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (284,851)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**		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)**	$ 1,275,146	24 *

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

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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	$ 3,124,425	1
2	Discounts and Allowances for all Levels	(1,229,754)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,894,671	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,726,675	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,726,675	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	8,463	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	138,656	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,612	19
20	Radiology and X-Ray	2,120	20
21	Other Medical Services	13,676	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 189,527	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL		28
28a	Misc Revenue	(115,793)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (115,793)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,695,160	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	627,536	31
32	Health Care	1,902,592	32
33	General Administration	785,908	33
	B. Capital Expense		
34	Ownership	421,169	34
	C. Ancillary Expense		
35	Special Cost Centers	132,728	35
36	Provider Participation Fee	112,817	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,982,750	40
41	**Income before Income Taxes (line 30 minus line 40)****	(287,590)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (287,590)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 544,056	44
45	Private Pay - Net Inpatient Revenue	1,174,588	45
46	Medicare - Net Inpatient Revenue	1,195,107	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	786,660	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,805,739)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,894,671	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: 1/1/17 Ending: 12/31/17

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	1,968	2,076	$ 74,856	$ 36.06	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	7,835	8,174	213,147	26.08	3
4	Licensed Practical Nurses	14,129	14,814	358,687	24.21	4
5	CNAs & Orderlies	43,214	44,877	526,597	11.73	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,870	2,022	28,105	13.90	9
10	Activity Assistants	2,903	2,989	28,537	9.55	10
11	Social Service Workers	3,594	3,802	71,473	18.80	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,878	1,985	26,305	13.25	13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	7,811	8,160	88,505	10.85	15
16	Dishwashers	3,087	3,182	26,855	8.44	16
17	Maintenance Workers	2,327	2,449	56,098	22.91	17
18	Housekeepers	6,576	6,830	62,851	9.20	18
19	Laundry	7,679	8,049	86,753	10.78	19
20	Administrator	1,936	2,145	96,712	45.09	20
21	Assistant Administrator	1,024	1,068	27,715	25.95	21
22	Other Administrative	0	0	0		22
23	Office Manager	1,965	2,077	48,323	23.27	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,988	2,086	33,286	15.96	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	772	795	11,913	14.98	33
34	TOTAL (lines 1 - 33)	112,556	117,580	$ 1,866,718 *	$ 15.88	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		$ 4,935	V01-3	35
36	Medical Director		21,000	V09-3	36
37	Medical Records Consultant		2,080	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,586	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,428	V11-3	44
45	Social Service Consultant		1,428	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,457		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 Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Reed	Administrator		$ 77,635
Erica Otto	Administrator		19,077
Emily Hays	Asst. Administrator		17,308
Katie Henderson	Asst. Administrator		4,000
Rachel Fralick	Asst. Administrator		6,407
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,427

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM US LLP	Accounting Fees	$ 23,305
HAWKES & HASTINGS ACCOUNT	Accounting Fees	1,500
MARGEL PEDDICORD	Accounting Fees	3,200
PLANTE & MORAN, PLLC	Accounting Fees	2,600
State of Illinois	Accounting Fees	5
Providigm, LLC	Data Processing	2,090
ABILITY NETWORK INC.	Data Processing	6,286
ITV3	Data Processing	2,365
KRONOS	Data Processing	12,508
PointClickCare Technologies Inc.	Data Processing	24,576
Provantage LLC	Data Processing	2,275
SEAN MIKEL	Data Processing	7,820
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 88,530

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,903
Unemployment Compensation Insurance	
FICA Taxes	209,752
Employee Health Insurance	129,888
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Misc Benefits	3,819
TOTAL (agree to Schedule V, line 22, col.8)	$ 378,362

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	8,793
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Maintenance Subscriptions/Dues	1,789
Activities Subscriptions/Dues	60
Social Services Subscriptions/Dues	520
Admin Subscriptions/Dues	722
INHAA	110
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,994

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
CPR Training	418
ILHCA	1,245
NCCDP	1,085
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,748

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/17 Ending: 12/31/17

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 - 110**

(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? **N/A**

(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? **N/A**

(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? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,040** Line **10-2**

(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. **N/A**

(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. $ **112,817**
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. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
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? **N/A**
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. $ **N/A**

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

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees