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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0055871

Facility Name: HALLMARK HC OF CARLINVILLE

Address: 826 NORTH HIGH ST (Number) CARLINVILLE (City) 62626 (Zip Code)

County: MACOUPIN

Telephone Number: 217-854-9606 **Fax #** 217-854-8484

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2019

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: AARON MAUER **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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) 5/28/2021 (Date)
(Type or Print Name) Shully Lichtman
(Title) Manager

Paid Preparer

(Signed) 5/27/2021 (Date)
(Print Name and Title) AARON MAUER, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 N/A

	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	49	Skilled (SNF)	49	17,934	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	49	TOTALS	49	17,934	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	8,883	1,112	1,785	11,780	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,883	1,112	1,785	11,780	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.69%

D. How many bed reserve days during this year were paid by the Department?
NONE (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)
N/A

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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 9/1/2019

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/2019 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 1,660

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	115,710	8,400	3,088	127,198		127,198	6,374	133,572			1
2	Food Purchase		70,618		70,618		70,618		70,618			2
3	Housekeeping	90,202	7,601		97,803		97,803		97,803			3
4	Laundry		4,134		4,134		4,134		4,134			4
5	Heat and Other Utilities			82,863	82,863		82,863		82,863			5
6	Maintenance	15,093	22,469	21,213	58,775		58,775	2,312	61,087			6
7	Other (specify):*											7
8	**TOTAL General Services**	221,005	113,222	107,164	441,391		441,391	8,685	450,076			8
	B. Health Care and Programs											
9	Medical Director			13,100	13,100		13,100		13,100			9
10	Nursing and Medical Records	559,352	116,129	173,284	848,765		848,765	16,182	864,947			10
10a	Therapy			238,527	238,527		238,527		238,527			10a
11	Activities	21,233	5,558		26,791		26,791		26,791			11
12	Social Services	51,227		4,865	56,092		56,092		56,092			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	631,812	121,687	429,776	1,183,275		1,183,275	16,182	1,199,457			16
	C. General Administration											
17	Administrative	80,854			80,854		80,854	42,863	123,717			17
18	Directors Fees											18
19	Professional Services			168,606	168,606		168,606	(70,655)	97,951			19
20	Dues, Fees, Subscriptions & Promotions			12,402	12,402		12,402		12,402			20
21	Clerical & General Office Expenses	29,992	17,848	185,665	233,505		233,505	(67,492)	166,013			21
22	Employee Benefits & Payroll Taxes			231,844	231,844		231,844	10,381	242,225			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,886	2,886		2,886	6	2,892			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,926	57,926		57,926		57,926			26
27	Other (specify):*											27
28	**TOTAL General Administration**	110,846	17,848	659,329	788,023		788,023	(84,897)	703,126			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	963,663	252,757	1,196,269	2,412,689		2,412,689	(60,030)	2,352,659			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 HC OF CARLINVILLE #0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			5,776	5,776		5,776	48,693	54,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,829	9,829		9,829	41,780	51,609			32
33	Real Estate Taxes			19,185	19,185		19,185	188	19,373			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							6,688	6,688			36
37	**TOTAL Ownership**			154,790	154,790		154,790	(22,651)	132,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			41,884	41,884		41,884		41,884			38
39	Ancillary Service Centers		57,910		57,910		57,910		57,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,387	72,387		72,387		72,387			42
43	Other (specify):* **Bad Debt**			26,898	26,898		26,898	(26,898)				43
44	**TOTAL Special Cost Centers**		57,910	141,169	199,079		199,079	(26,898)	172,181			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	963,663	310,667	1,492,228	2,766,558		2,766,558	(109,579)	2,656,979			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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Reference	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	(16,644)	30		9
10	Interest and Other Investment Income	(1,370)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,000)	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	(26,898)	43		24
25	Fund Raising, Advertising and Promotional	(60,763)	21		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (118,675)		$	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)			34
35	Other- Attach Schedule	9,096	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 9,096		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (109,579)		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 HC OF CARLINVILLE

ID# 0055871

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	6,374	0	0	0	0	0	0	0	0	0	6,374	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	2,274	38	0	0	0	0	0	0	0	0	2,312	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	8,648	38	0	0	0	0	0	0	0	0	8,685	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	16,182	0	0	0	0	0	0	0	0	0	16,182	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	16,182	0	0	0	0	0	0	0	0	0	16,182	16
	C. General Administration													
17	Administrative	0	42,863	0	0	0	0	0	0	0	0	0	42,863	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	571	(71,226)	0	0	0	0	0	0	0	0	(70,655)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(73,763)	6,233	37	0	0	0	0	0	0	0	0	(67,492)	21
22	Employee Benefits & Payroll Taxes	0	10,375	6	0	0	0	0	0	0	0	0	10,381	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(73,763)	60,043	(71,178)	0	0	0	0	0	0	0	0	(84,897)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,763)	84,873	(71,140)	0	0	0	0	0	0	0	0	(60,030)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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	(16,644)	65,337	0	0	0	0	0	0	0	0	0	48,693	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,370)	43,150	0	0	0	0	0	0	0	0	0	41,780	32
33	Real Estate Taxes	0	188	0	0	0	0	0	0	0	0	0	188	33
34	Rent-Facility & Grounds	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	6,688	0	0	0	0	0	0	0	0	6,688	36
37	**TOTAL Ownership**	(18,014)	(11,325)	6,688	0	0	0	0	0	0	0	0	(22,651)	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):*	(26,898)	0	0	0	0	0	0	0	0	0	0	(26,898)	43
44	**TOTAL Special Cost Centers**	(26,898)	0	0	0	0	0	0	0	0	0	0	(26,898)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(118,675)	73,548	(64,452)	0	0	0	0	0	0	0	0	(109,579)	45

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
CREST ILLINOIS HOLDCO LLC	100	Cedar Ridge	Lebanon	Crest Consulting	Chicago	Consulting Co
		Hallmark of Perkin	Perkin	Crest Realty LLC	Chicago	Real Estate
		Highland Health Care	Highland	Crest Management	Chicago	Management Co
		Hilltop Care	Chareston			
		Jacksonville Care	Jacksonville			
		Paris Health	Paris			
		Sunrise Care	Virden			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Consulting Fee	$ 1	Crest Consulting		$ (1)	$ (1)	1
2	V	1	Dietary		Crest Consulting		6,374	6,374	2
3	V	6	Maintenance		Crest Consulting		2,274	2,274	3
4	V	10	Nursing and Medical Records		Crest Consulting		16,182	16,182	4
5	V	17	Administrative		Crest Consulting		42,863	42,863	5
6	V	21	Clerical & General Office Expenses		Crest Consulting		6,234	6,234	6
7	V	22	Employee Benefits & Payroll Taxes		Crest Consulting		10,375	10,375	7
8	V	19	Professional Services		Crest Realty LLC		571	571	8
9	V	30	Depreciation		Crest Realty LLC		65,337	65,337	9
10	V	32	Interest		Crest Realty LLC		43,150	43,150	10
11	V	33	Real Estate Taxes		Crest Realty LLC		188	188	11
12	V	34	Rent	120,000	Crest Realty LLC			(120,000)	12
13	V								13
14	Total			$ 120,001			$ 193,549	$ * 73,548	14

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

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	Crest Management		$ 38	$ 38	15
16	V	19	Professional Services	143,716	Crest Management		72,490	(71,226)	16
17	V	21	Clerical & General Office Expenses		Crest Management		37	37	17
18	V	22	Employee Benefits & Payroll Taxes		Crest Management		6	6	18
19	V	24	Travel and Seminar		Crest Management		6	6	19
20	V	36	Other (specify):*		Crest Management		6,688	6,688	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,716			$ 79,264	$ * (64,452)	39

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

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			Taylorville Care Center	Taylorville				1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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									$		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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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						$	$		$	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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Mortgage		X	Mortgage	Various		$	$ 993,289			$ 114,113	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 993,289			$ 114,113	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 993,289			$ 114,113	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA 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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	19,520	2
3. Under or (over) accrual (line 2 minus line 1).	$	19,520	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(335)	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.	$	19,185	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015		8
2016		9
2017		10
2018		11
2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HALLMARK HC OF CARLINVILLE COUNTY MACOUPIN

FACILITY IDPH LICENSE NUMBER 0055871

CONTACT PERSON REGARDING THIS REPORT AARON MAUER

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-001-068-00	LONG TERM CARE PROPERTY	$ 19,520.34	$ 19,520.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,520.34	$ 19,520.34

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,488 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

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

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

D. Does the Operating Entity? [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).

NONE

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	49		2019		$ 795,520	$ 20,398	39	$ 20,398	$ (0)	$ 39,938	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Drywall work- dementia unit			10/31/2019	311	21	39	8	(13)	26	9
10	buildout of new dementia unit			12/17/2019	18,400	1,227	39	472	(755)	1,329	10
11	Door Lock system Dementia unit			12/20/2019	6,988	466	39	179	(287)	505	11
12	parking lot repave			5/21/2020	7,986	355	39	102	(253)	355	12
13	concrete slab - Dementia unit			7/8/2020	3,900	130	39	50	(80)	130	13
14	Facility signage - throughout the buildingq			10/22/2020	6,385	106	39	82	(25)	106	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

*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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 839,491	$ 22,703		$ 21,291	$ (1,411)	$ 42,389	70

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

Facility Name & ID Number HALLMARK HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 149,160	$ 44,939	$ 29,832	$ (15,107)	5	$ 32,414	71
72	Current Year Purchases	33,410	3,462	3,341	(121)	5	4,052	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 182,570	$ 48,401	$ 33,173	$ (15,228)		$ 36,466	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,022,060	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 71,104	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,464	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,640)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 78,855	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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.

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	10a-3	hrs	$	1,482	$ 111,848	$	1,482	$ 111,848	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		163	14,089		163	14,089	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,579	112,589		1,579	112,589	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				52,667		52,667	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					921		921	12
13	Other (specify): Lab	39-2					4,321		4,321	13
14	TOTAL			$	3,224	$ 238,526	$ 57,910	3,224	$ 296,436	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 HC OF CARLINVILLE # 0055871 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 107,901	$ 442,718	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	572,492	572,492	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,981	71,981	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	39,529	39,529	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 791,903	$ 1,126,720	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,720	13
14	Buildings, at Historical Cost		795,520	14
15	Leasehold Improvements, at Historical Cost	43,971	43,971	15
16	Equipment, at Historical Cost	33,410	182,570	16
17	Accumulated Depreciation (book methods)	(6,508)	(78,860)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,128	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement Reserve		14,725	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 70,873	$ 1,120,774	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 862,776	$ 2,247,494	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,230	$ 244,008	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,807	22,807	28
29	Short-Term Notes Payable		74,611	29
30	Accrued Salaries Payable	55,881	(55,881)	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,550	29,550	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,185	19,185	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 370,653	$ 334,280	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	213,678	213,678	39
40	Mortgage Payable		993,289	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)**	$ 213,678	$ 1,206,967	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 584,331	$ 1,541,247	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 278,445	$ 706,247	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 862,776	$ 2,247,494	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (10,632)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (10,632)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	303,361	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	(14,285)	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)**	$ 289,076	17
	B. Transfers (Itemize):		
18	Rounding	1	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 278,445	24 *

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

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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	$ 2,518,500	1
2	Discounts and Allowances for all Levels	(2,587)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,515,913	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,555	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 170,555	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	380,142	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(3,864)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,972	19
20	Radiology and X-Ray	31	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 381,281	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,370	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,370	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		800	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 800	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,069,919	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	441,391	31
32	Health Care	1,183,275	32
33	General Administration	788,023	33
	B. Capital Expense		
34	Ownership	154,790	34
	C. Ancillary Expense		
35	Special Cost Centers	199,079	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,766,558	40
41	**Income before Income Taxes (line 30 minus line 40)****	303,361	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 303,361	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,431,169	44
45	Private Pay - Net Inpatient Revenue	179,462	45
46	Medicare - Net Inpatient Revenue	909,257	46
47	Other-(specify) Insurance	(27,155)	47
48	Other-(specify) Hospice	23,180	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,515,913	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.**

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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	1,615	1,813	$ 76,746	$ 42.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,634	1,753	37,869	21.60	3
4	Licensed Practical Nurses	6,307	6,887	161,711	23.48	4
5	CNAs & Orderlies	18,776	20,168	270,816	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7	10	660	66.00	9
10	Activity Assistants	1,609	1,665	17,454	10.48	10
11	Social Service Workers	2,088	2,175	43,466	19.98	11
12	Dietician					12
13	Food Service Supervisor	280	302	4,070	13.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,052	9,695	95,111	9.81	15
16	Dishwashers					16
17	Maintenance Workers	1,979	2,089	39,801	19.05	17
18	Housekeepers	5,462	5,621	49,508	8.81	18
19	Laundry					19
20	Administrator	2,024	2,192	69,827	31.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,143	2,231	46,953	21.05	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					31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,040	2,105	49,671	23.60	33
34	TOTAL (lines 1 - 33)	55,016	58,706	$ 963,663 *	$ 16.42	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		$		35
36	Medical Director	Monthly	6,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	200	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,800		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	298	5,154		51
52	Certified Nurse Assistants/Aides	35	1,552		52
53	TOTAL (lines 50 - 52)	332	$ 6,706		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALBERS CHASITY L	Administrator	0	$ 68,968
ALICEA TONYA K	Administrator	0	11,886
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,854

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Gutnicki LLP	Legal fees	$ 112
Falcon, Rappaport & Berkin	Legal fees	500
Capital Financa	Legal fees	79
Pease & Associates, LLC:	Accounting Fees	6,259
GGM	Accounting Fees	6,000
CFG Finance	Professional Fees	1,469
V Vorp	Professional Fees	460
Mayer Magence	Professional Fees	81
LTC Consulting	Professional Fees	2,071
Pathway Health Services	Professional Fees	200
Apex Consulting	Professional Fees	2,750
		148,625
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 168,606

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,201
Unemployment Compensation Insurance	11,997
FICA Taxes	90,747
Employee Health Insurance	43,290
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	38,657
Background Checks	892
COVID Benefits	28,441
TOTAL (agree to Schedule V, line 22, col.8)	$ 242,225

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
HCCI	7,497
IL Council	441
Chamber of Commerce	500
Licnese Fees	3,964
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,402

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel & Seminars	2,892
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,892

**See instructions.

Activated Insights	Professional Fees	722
Pease and Associates	Professional Fees	389
Crest Management	Management fees	143,715
CFG Finance	Legal Fees	3,254
Dovid Stern	Professional Fees	19
MTS Consultin	Professional Fees	525

148,625

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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. **HCCI $7,497**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(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? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,786** Line **10-02**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **72,387**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ____ Has any meal income been offset against related costs? **NO** 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? **100% LN**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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 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. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.