		FOR BHF USE					

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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: 0056622

Facility Name: HALLMARK HEALTHCARE OF PEKIN

Address: 2501 ALLENTOWN ROAD (Number) PEKIN (City) 61554 (Zip Code)

County: TAZEWELL

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2020

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: 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 01/01/20 to 12/31/20 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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,986	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	25,986	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	4,886	4,815	4,671	14,372	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,886	4,815	4,671	14,372	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.31%

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 4/1/2020

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2020 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 2,551

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	116,643	20,545	984	138,172		138,172	7,776	145,948			1
2	Food Purchase		90,633		90,633		90,633		90,633			2
3	Housekeeping	99,354	8,662		108,016		108,016		108,016			3
4	Laundry		4,906		4,906		4,906		4,906			4
5	Heat and Other Utilities			76,905	76,905		76,905		76,905			5
6	Maintenance	40,131	21,197	25,386	86,714		86,714	2,833	89,547			6
7	Other (specify):*											7
8	TOTAL General Services	256,128	145,943	103,275	505,346		505,346	10,609	515,955			8
	B. Health Care and Programs											
9	Medical Director			15,750	15,750		15,750		15,750			9
10	Nursing and Medical Records	1,014,660	172,502	241,728	1,428,890		1,428,890	19,743	1,448,633			10
10a	Therapy			306,220	306,220		306,220		306,220			10a
11	Activities	45,347	4,359		49,706		49,706		49,706			11
12	Social Services	40,700		5,439	46,139		46,139		46,139			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,100,707	176,861	569,137	1,846,705		1,846,705	19,743	1,866,448			16
	C. General Administration											
17	Administrative	79,250			79,250		79,250	52,295	131,545			17
18	Directors Fees											18
19	Professional Services			263,491	263,491		263,491	(109,840)	153,651			19
20	Dues, Fees, Subscriptions & Promotions			5,845	5,845		5,845		5,845			20
21	Clerical & General Office Expenses	102,347	20,106	282,321	404,774		404,774	(87,429)	317,345			21
22	Employee Benefits & Payroll Taxes			268,173	268,173		268,173	12,667	280,840			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,019	1,019		1,019	9	1,028			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			132,822	132,822		132,822		132,822			26
27	Other (specify):*											27
28	TOTAL General Administration	181,597	20,106	953,671	1,155,374		1,155,374	(132,299)	1,023,075			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,538,432	342,910	1,626,083	3,507,425		3,507,425	(101,947)	3,405,478			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 HEALTHCARE OF PEKIN #0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			5,592	5,592		5,592	47,843	53,435			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,651	4,651		4,651	80,858	85,509			32
33	Real Estate Taxes			28,157	28,157		28,157	352	28,509			33
34	Rent-Facility & Grounds			225,000	225,000		225,000	(225,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							10,414	10,414			36
37	**TOTAL Ownership**			263,400	263,400		263,400	(85,533)	177,867			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			6,618	6,618		6,618		6,618			38
39	Ancillary Service Centers		112,955		112,955		112,955		112,955			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			88,197	88,197		88,197		88,197			42
43	Other (specify):* **Bad Debt**			41,158	41,158		41,158	(41,158)				43
44	**TOTAL Special Cost Centers**		112,955	135,973	248,928		248,928	(41,158)	207,770			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,538,432	455,865	2,025,456	4,019,753		4,019,753	(228,638)	3,791,115			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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(32,140)	30		9
10	Interest and Other Investment Income	(48)	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	(1,950)	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	(54,403)	21		23
24	Bad Debt	(41,158)	43		24
25	Fund Raising, Advertising and Promotional				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)**	$ (129,699)		$	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	(98,939)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (98,939)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (228,638)		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 HEALTHCARE OF PEKIN

ID# 0056622

Report Period Beginning: 01/01/20

Ending: 12/31/20

	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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	7,776	0	0	0	0	0	0	0	0	0	7,776	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	2,774	58	0	0	0	0	0	0	0	0	2,833	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	10,551	58	0	0	0	0	0	0	0	0	10,609	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	19,743	0	0	0	0	0	0	0	0	0	19,743	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	19,743	0	0	0	0	0	0	0	0	0	19,743	16
	C. General Administration													
17	Administrative	0	52,295	0	0	0	0	0	0	0	0	0	52,295	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,071	(110,911)	0	0	0	0	0	0	0	0	(109,840)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(56,353)	(31,135)	58	0	0	0	0	0	0	0	0	(87,429)	21
22	Employee Benefits & Payroll Taxes	0	12,658	9	0	0	0	0	0	0	0	0	12,667	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	9	0	0	0	0	0	0	0	0	9	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**	(56,353)	34,889	(110,836)	0	0	0	0	0	0	0	0	(132,299)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,353)	65,183	(110,777)	0	0	0	0	0	0	0	0	(101,947)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(32,140)	79,983	0	0	0	0	0	0	0	0	0	47,843	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48)	80,906	0	0	0	0	0	0	0	0	0	80,858	32
33	Real Estate Taxes	0	352	0	0	0	0	0	0	0	0	0	352	33
34	Rent-Facility & Grounds	0	(225,000)	0	0	0	0	0	0	0	0	0	(225,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	10,414	0	0	0	0	0	0	0	0	10,414	36
37	**TOTAL Ownership**	(32,188)	(63,759)	10,414	0	0	0	0	0	0	0	0	(85,533)	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):*	(41,158)	0	0	0	0	0	0	0	0	0	0	(41,158)	43
44	**TOTAL Special Cost Centers**	(41,158)	0	0	0	0	0	0	0	0	0	0	(41,158)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(129,699)	1,424	(100,363)	0	0	0	0	0	0	0	0	(228,638)	45

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 II LLC	95	Cedar Ridge	Lebanon	Crest Consulting	Chicago	Consulting Co
ERIC CLARK	5	Hallmark of Carnville	Carniville	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	Management Fees	$ 38,741	Crest Consulting		$	$ (38,741)	1
2	V	1	Dietary		Crest Consulting		7,776	7,776	2
3	V	6	Maintenance		Crest Consulting		2,774	2,774	3
4	V	10	Nursing and Medical Records		Crest Consulting		19,743	19,743	4
5	V	17	Administrative		Crest Consulting		52,295	52,295	5
6	V	21	Clerical & General Office Expenses		Crest Consulting		7,606	7,606	6
7	V	22	Employee Benefits & Payroll Taxes		Crest Consulting		12,658	12,658	7
8	V	19	Professional Services		Crest Realty LLC		1,071	1,071	8
9	V	30	Depreciation		Crest Realty LLC		79,983	79,983	9
10	V	32	Interest		Crest Realty LLC		80,906	80,906	10
11	V	33	Real Estate Taxes		Crest Realty LLC		352	352	11
12	V	34	Rent	225,000	Crest Realty LLC			(225,000)	12
13	V								13
14	Total			$ 263,741			$ 265,165	$ * 1,424	14

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

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 58	$ 58	15
16	V	19	Professional Services	223,790	Crest Management		112,879	(110,911)	16
17	V	21	Clerical & General Office Expenses		Crest Management		58	58	17
18	V	22	Employee Benefits & Payroll Taxes		Crest Management		9	9	18
19	V	24	Travel and Seminar		Crest Management		9	9	19
20	V	36	Other (specify):*		Crest Management		10,414	10,414	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			$ 223,790			$ 123,427	$ * (100,363)	39

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

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$	$ 2,483,223			$ 114,113	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,483,223			$ 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)						$	$ 2,483,223			$ 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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.)	$	38,528	2
3. Under or (over) accrual (line 2 minus line 1).	$	38,528	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(10,371)	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.	$	28,157	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 HEALTHCARE OF PEKIN COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0056622

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.	04-10-01-407-018	LTC FACILITY	$ 38,527.64	$ 38,527.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,527.64	$ 38,527.64

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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2019		$ 1,277,003	$ 9,936	39	$ 32,744	$ 22,808	$ 9,936	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pave sidewalk for facility			6/1/2020	3,450	134	39	44	(90)	134	9
10	mixing valves shower room			6/8/2020	1,971	77	39	25	(51)	77	10
11	sprinkler system throughout building			9/29/2020	9,917	220	39	127	(93)	220	11
12	gutter replacment office area			10/19/2020	2,750	46	39	35	(11)	46	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

*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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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)		$ 1,295,091	$ 10,413		$ 32,976	$ 22,563	$ 10,413	70

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

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 239,438	$ 70,047	$ 14,009	$ (56,038)		$ 50,525	71
72	Current Year Purchases	64,500	5,115	6,450	1,335		5,115	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 303,938	$ 75,162	$ 20,459	$ (54,703)		$ 55,640	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)	$ 1,599,029	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,575	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,435	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (32,140)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 66,053	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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	1,345	$ 110,597	$	1,345	$ 110,597	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		548	47,401		548	47,401	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,806	148,222		1,806	148,222	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				93,455		93,455	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					4,179		4,179	12
13	Other (specify): Lab	39-2					15,321		15,321	13
14	TOTAL			$	3,699	$ 306,220	$ 112,955	3,699	$ 419,175	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 HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 102,562	$ 437,379	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,189,317	2,186,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,000	60,000	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	89,320	89,320	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,441,199	$ 2,773,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,000	13
14	Buildings, at Historical Cost		775,000	14
15	Leasehold Improvements, at Historical Cost	18,088	18,088	15
16	Equipment, at Historical Cost	64,500	297,000	16
17	Accumulated Depreciation (book methods)	(5,592)	(66,053)	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 (spe Goodwill		387,500	22
23	Other(specify): Replacement Reserve		14,725	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 76,996	$ 1,694,388	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,518,195	$ 4,467,458	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 365,301	$ 366,079	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,019	8,019	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,041	96,041	30
31	Accrued Taxes Payable (excluding real estate taxes)	84,483	84,483	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,001	37,001	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)**	$ 590,845	$ 591,623	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	400,584	400,584	39
40	Mortgage Payable		2,483,223	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)**	$ 400,584	$ 2,883,807	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 991,429	$ 3,475,430	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 526,766	$ 992,028	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,518,195	$ 4,467,458	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	526,767	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	( )	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)**	$ 526,767	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)**	$ 526,766	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	$ 4,026,578	1
2	Discounts and Allowances for all Levels	(9,488)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,017,090	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	153,393	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 153,393	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	375,678	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	200	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 375,878	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		111	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 111	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,546,520	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	505,346	31
32	Health Care	1,846,705	32
33	General Administration	1,155,374	33
	B. Capital Expense		
34	Ownership	263,400	34
	C. Ancillary Expense		
35	Special Cost Centers	248,928	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,019,753	40
41	**Income before Income Taxes (line 30 minus line 40)****	526,767	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 526,767	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 845,055	44
45	Private Pay - Net Inpatient Revenue	1,027,932	45
46	Medicare - Net Inpatient Revenue	1,418,951	46
47	Other-(specify) Insurance	531,991	47
48	Other-(specify) Hospice	193,161	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,017,090	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	1,488	1,613	$ 65,880	$ 40.84	1
2	Assistant Director of Nursing	400	403	18,476	45.85	2
3	Registered Nurses	5,836	6,248	223,285	35.74	3
4	Licensed Practical Nurses	7,831	8,246	243,989	29.59	4
5	CNAs & Orderlies	30,089	31,666	494,254	15.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	837	842	16,208	19.25	9
10	Activity Assistants	2,251	2,281	26,468	11.60	10
11	Social Service Workers	14,440	1,505	33,652	22.36	11
12	Dietician					12
13	Food Service Supervisor	1,325	1,403	28,346	20.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,961	7,281	85,554	11.75	15
16	Dishwashers					16
17	Maintenance Workers	1,376	1,505	40,592	26.97	17
18	Housekeepers	8,387	8,715	96,546	11.08	18
19	Laundry					19
20	Administrator	1,264	1,289	58,797	45.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,892	4,160	96,551	23.21	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	269	318	9,835	30.93	33
34	TOTAL (lines 1 - 33)	86,646	77,475	$ 1,538,433 *	$ 19.86	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	15,750	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				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)		$ 15,750		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	440	$ 41,942	10-3	50
51	Licensed Practical Nurses	1,157	73,638	10-3	51
52	Certified Nurse Assistants/Aides	54	2,677	10-3	52
53	TOTAL (lines 50 - 52)	1,650	$ 118,257		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
HOLCOMB MICHAEL A	Administrator	0	$ 13,563
WILLIAMS CAROL A	0	0	65,687
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 79,250

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
Crest Management	Management fees	$ 223,790
Gutniki LLP	Legal Fees	112
CFG Finance	Legal Fees	4,830
Falcon, Rappaport & Berkin	Legal Fees	500
Pease & Associates	Accounting Fees	10,289
GGM	Accounting Fees	6,000
Pease & Associates	Professional Fees	506
Dovid Stern	Professional Fees	19
Pathway Health Services	Professional Fees	209
Apex Global Solutions	Professional Fees	2,750
Activiated Insights	Professional Fees	727
See Attached Schedule		13,760
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 263,491

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,185
Unemployment Compensation Insurance	22,869
FICA Taxes	136,307
Employee Health Insurance	17,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	15,467
Background Checks	794
COVID Benefits	46,565
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,840

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	2,840
Chamber of Commerce	500
Senior Care Network	90
License Fees	2,415
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,845

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel & Seminar	1,028
Seminar Expense	
Education & Seminar	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,028

**See instructions.

Kollel	Professional Fees	180
Compliance Consulting Group	Professional Fees	5,700
LTC Consulting	Professional Fees	6,079
Vcorp	Professional Fees	383
MTS Consulting	Professional Fees	201
Mayer Magence	Professional Fees	244
CFG	Professional Fees	973
		13,760

Facility Name & ID Number HALLMARK HEALTHCARE OF PEKIN # 0056622 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 $2840

(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. $ 15,719 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. $ 88,197
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 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.