

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>36343</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Hallmark House Nursing Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> 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.																							
Address: <u>2501 Allentown Rd.</u> <u>Pekin</u> <u>61554</u>																									
Number City Zip Code																									
County: <u>Tazwell</u>																									
Telephone Number: <u>309-347-3121</u> Fax # <u>309-347-3607</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountant's Compilation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Margel S. Peddicord</u> <u>CPA</u></td></tr><tr><td>(Firm Name & Address) <u>Margel S. Peddicord, CPA</u> <u>5300 Jaeger Dr., Springfield, IL 62711</u></td></tr><tr><td>(Telephone) <u>217-787-8554</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>See Accountant's Compilation Report</u>	Paid Preparer	(Date) _____	(Print Name and Title) <u>Margel S. Peddicord</u> <u>CPA</u>	(Firm Name & Address) <u>Margel S. Peddicord, CPA</u> <u>5300 Jaeger Dr., Springfield, IL 62711</u>	(Telephone) <u>217-787-8554</u> Fax # ()												
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	(Telephone) <u>217-787-8554</u> Fax # ()																								
Date of Initial License for Current Owners: <u>5/01/90</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Margel S. Peddicord, CPA</u>																									
Telephone Number: <u>217-787-8554</u> Email Address: _____																									

Facility Name & ID Number Hallmark House Nursing Center

36343 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,915</u>	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	<u>71</u>	TOTALS	<u>71</u>	<u>25,915</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,391</u>	<u>10,409</u>	<u>4,083</u>	<u>23,883</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,391</u>	<u>10,409</u>	<u>4,083</u>	<u>23,883</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.16%

D. How many bed-hold days during this year were paid by the Department? 483 (Do not include bed-hold days in Section B.)

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

None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/20/80

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 71 and days of care provided 4,083

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Hallmark House Nursing Center** # **36343** Report Period Beginning: **01/01/11** Ending: **12/31/11**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	227,465	24,311	68,465	320,241		320,241	(101,965)	218,276			1
2	Food Purchase		259,664		259,664	(18,526)	241,138	(46,801)	194,337			2
3	Housekeeping	147,283	27,960	2,028	177,271		177,271		177,271			3
4	Laundry	38,200	14,788	1,554	54,542		54,542		54,542			4
5	Heat and Other Utilities			85,107	85,107		85,107		85,107			5
6	Maintenance	64,025	7,868	95,842	167,735		167,735		167,735			6
7	Other (specify):*											7
8	TOTAL General Services	476,973	334,591	252,996	1,064,560	(18,526)	1,046,034	(148,766)	897,268			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,530,904	104,241	49,304	1,684,449		1,684,449		1,684,449			10
10a	Therapy	71,897		271,351	343,248		343,248		343,248			10a
11	Activities	91,237	3,722	12,711	107,670		107,670	(8,070)	99,600			11
12	Social Services	34,932		1,360	36,292		36,292		36,292			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,728,970	107,963	340,726	2,177,659		2,177,659	(8,070)	2,169,589			16
	C. General Administration											
17	Administrative	91,534			91,534		91,534		91,534			17
18	Directors Fees											18
19	Professional Services			17,963	17,963		17,963	1,200	19,163			19
20	Dues, Fees, Subscriptions & Promotions			34,269	34,269		34,269	(6,425)	27,844			20
21	Clerical & General Office Expenses	67,584	11,666	66,912	146,162	(11,380)	134,782		134,782			21
22	Employee Benefits & Payroll Taxes			387,045	387,045	18,526	405,571		405,571			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,267	4,267	7,113	11,380		11,380			24
25	Other Admin. Staff Transportation					4,267	4,267		4,267			25
26	Insurance-Prop.Liab.Malpractice			36,245	36,245		36,245		36,245			26
27	Other (specify):*			34,142	34,142		34,142	(34,142)				27
28	TOTAL General Administration	159,118	11,666	580,843	751,627	18,526	770,153	(39,367)	730,786			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,365,061	454,220	1,174,565	3,993,846		3,993,846	(196,203)	3,797,643			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			47,842	47,842		47,842	40,403	88,245			30
31	Amortization of Pre-Op. & Org.							460	460			31
32	Interest			5,974	5,974		5,974	32,083	38,057			32
33	Real Estate Taxes			32,838	32,838		32,838		32,838			33
34	Rent-Facility & Grounds			272,417	272,417		272,417	(272,417)				34
35	Rent-Equipment & Vehicles			3,694	3,694		3,694		3,694			35
36	Other (specify):*											36
37	TOTAL Ownership			362,765	362,765		362,765	(199,471)	163,294			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,292	6,252	188,544		188,544		188,544			39
40	Barber and Beauty Shops	21,631			21,631		21,631		21,631			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,065	78,065		78,065		78,065			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	21,631	182,292	84,317	288,240		288,240		288,240			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,386,692	636,512	1,621,647	4,644,851		4,644,851	(395,674)	4,249,177			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,415	30		9
10	Interest and Other Investment Income	(12,123)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,142)	27		24
25	Fund Raising, Advertising and Promotional	(6,425)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(156,836)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (182,111)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(213,563)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (213,563)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (395,674)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Remove soda & Avon cost	\$ (6,556)	11	1
2	Remove vending cost	(1,514)	11	2
3	Catering vehicle expense	(16,286)	1	3
4	Catering advertizing expense	(6,298)	1	4
5	Catering labor	(39,537)	1	5
6	Catering supplies	(5,116)	1	6
7	Catering food	(46,801)	2	7
8	Other catering cost (assistant and delivery)	(34,728)	1	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(156,836)		49

Summary A

12/31/11

[illegible]

Summary B

Facility Name & ID Number

36343

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

[illegible]

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
Lloyd Miller	100%			Advanced Capital	Walnut Creek	Management co.
				Pekin Investment	Pekin	Building co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 272,417	Pekin Investment Group, LLC		\$	(272,417)	1
2	V	19	Professional Fees		Pekin Investment Group, LLC		1,200	1,200	2
3	V	32	Interest		Pekin Investment Group, LLC		44,206	44,206	3
4	V	30	Depreciation		Pekin Investment Group, LLC		12,988	12,988	4
5	V	31	Amortization		Pekin Investment Group, LLC		460	460	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 272,417			\$ 58,854	\$ * (213,563)	14

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

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	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Hallmark House Nursing Center # 36343 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		NA				\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1			x	Mortgage			\$				\$	44,206	1	
2	First National Bank		x	Van Loan		5/7/07		25,427		5/7/12	6.3980		2	
3	First National Bank		x	HHR loan		10/8/07		18,011		10/8/12	6.2910		3	
4													4	
5													5	
	Working Capital													
6	Busey Bank		x	Line of Credit								5,974	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	43,438	\$			\$	50,180	9
	B. Non-Facility Related*													
10	See investment income offset											(12,123)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	(12,123)	14
15	TOTALS (line 9+line14)						\$	43,438	\$			\$	38,057	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	32,889	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.)			\$	33,903	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,014	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	31,824	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.			\$	32,838	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	29,522	8	
		2007	30,157	9	
		2008	31,953	10	
		2009	32,838	11	
		2010	33,903	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Center COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 36343

CONTACT PERSON REGARDING THIS REPORT Margel S. Peddicord, CPA

TELEPHONE 217-787-8554 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	01-10-01-407-018	LTC facility	\$ 33,903.00	\$ 33,903.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 33,903.00	\$ 33,903.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,782

B. General Construction Type: Exterior BrickFrame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (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?

☒ (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

☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing facility	292,455	1980	\$ 57,000	1
2					2
3	TOTALS	292,455		\$ 57,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	71		1980	1976	\$ 510,430	\$ 12,988	40	\$ 12,761	\$ (227)	\$ 319,022	4
5											5
6			1980	1976	290,586	32,796	40	7,265	(25,531)	174,366	6
7											7
8											8
	Improvement Type**										
9	Building Improvements		1977		41,421		20	1,035	1,035	26,916	9
10	Building Improvements		1978		6,473		20			6,473	10
11	Building Improvements		1981		10,987		20	275	275	7,146	11
12	Building Improvements		1982		12,368		20	309	309	8,037	12
13	Building Improvements		1983		7,662		20	191	191	4,971	13
14	Building Improvements		1984		2,343		20	58	58	1,512	14
15	Building Improvements		1986		17,604		20	482	482	12,224	15
16	Building Improvements		1987		7,275		20			7,275	16
17	Building Improvements		1988		42,911		20			42,911	17
18	Building Improvements		1989		15,387		20	(203)	(203)	15,387	18
19	Building Improvements		1990		55,198		20	1,464	1,464	30,744	19
20	Building Improvements		1991		11,136		20	360	360	11,136	20
21	Building Improvements		1993		53,652		20	528	528	21,207	21
22	Building Improvements		1994		45,374		20	(562)	(562)	45,374	22
23	Building Improvements		1995		110,087		20	4,438	4,438	75,294	23
24	Building Improvements		1996		26,910		20	450	450	17,976	24
25	Building Improvements		1997		43,197		20	2,250	2,250	39,782	25
26	Building Improvements		1998		118,189		20	5,994	5,994	80,920	26
27	Building Improvements		1999		29,258		20	897	897	21,995	27
28	Building Improvements		2000		253,531		20	9,642	9,642	121,773	28
29	Building Improvements		2001		21,498		20	1,312	1,312	14,432	29
30	Building Improvements		2002		22,175		20	1,755	1,755	17,550	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hallmark House Nursing Center

36343

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Remodel bathroom	2003	\$ 2,237	\$	20	\$ 112	\$ 112	\$ 1,008	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	1,773	38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20	68	68	615	39
40	Griddle Exhaust	2003	2,076		20	104	104	1,143	40
41	Circuits & Outlets	2003	2,926		20	146	146	1,316	41
42	Heater in room 116	2003	1,100		20	55	55	495	42
43	Kitchen Remodel	2003	5,967		20	298	298	2,684	43
44	Blinds	2003	833		20	42	42	376	44
45	Boiler Pump	2003	1,694		20	85	85	735	45
46	Boiler Repair	2003	2,247		20	112	112	936	46
47	Glass Doors	2003	1,602		20	80	80	640	47
48	Boiler	2003	1,154		20	58	58	366	48
49	Lighting	2004	610		20	31	31	246	49
50	Blinds, Valance	2004	8,175		20	409	409	3,507	50
51	Light Fixture	2004	759		20	38	38	304	51
52	Blinds & vallance	2004	9,773		20	489	489	4,144	52
53	Boiler	2004	4,586		20	229	229	1,834	53
54	Outside lighting	2004	3,155		20	158	158	1,263	54
55	Roof	2004	4,419		20	221	221	1,768	55
56	Bathroom remodel	2004	1,054		20	53	53	422	56
57	Cabinets & countertop	2004	890		20	45	45	358	57
58	Bathroom flooring	2004	546		20	27	27	218	58
59	Air conditioner	2004	3,278		20	164	164	1,312	59
60	Bathroom remodel	2004	2,000		20	100	100	800	60
61	Cabinets & countertop	2004	460		20	23	23	184	61
62	Cabinets in beverage centger	2004	250		20	13	13	102	62
63	Houthous	2004	7,929		20	396	396	3,170	63
64	Fire Door	2004	879		20	44	44	352	64
65	Hot water heater	2004	650		20	33	33	262	65
66	Tub repairs	2004	539		20	27	27	216	66
67	Tub repairs	2004	500		20	25	25	133	67
68	Door locks	2004	985		20	49	49	394	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,834,235	\$ 45,784		\$ 54,632	\$ 8,848	\$ 1,157,499	70

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

Facility Name & ID Number Hallmark House Nursing Center

36343

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,834,235	\$ 45,784		\$ 54,632	\$ 8,848	\$ 1,157,499	1
2	Exhaust fan repairs	2004	717		20	36	36	288	2
3	Water heater repairs	2004	720		20	36	36	288	3
4	Plumbing repairs	2004	5,620		20	281	281	2,248	4
5	Garbage Disposals	2004	850		20	43	43	342	5
6	Storage room remodel	2004	696		20	35	35	279	6
7	Room Remodel	2004	4,496		20	225	225	1,799	7
8	Back sidewalk	2005	1,600		20	80	80	560	8
9	Fire door	2005	487		20	24	24	170	9
10	Front sidewalk	2005	1,700		20	85	85	595	10
11	Fire Dampers.	2005	747		20	37	37	261	11
12	Irrigation System	2005	7,750		20	388	388	2,714	12
13	Landscaping	2005	942		20	47	47	329	13
14	Landscaping	2005	6,028		20	301	301	2,106	14
15	Fish pond	2005	5,027		20	251	251	1,759	15
16	Office floor	2005	319		20	16	16	112	16
17	Walk in cooler floor	2005	800		20	40	40	280	17
18	Walk in freezer floor	2005	540		20	27	27	242	18
19	Water system pump	2005	852		20	43	43	299	19
20	Breaker panel replacement	2005	1,952		20	98	98	684	20
21	Public bath tile	2005	219		20	11	11	77	21
22	Wire fish pond	2005	1,016		20	51	51	357	22
23	Detectors	2005	860		20	43	43	301	23
24	Gutters	2005	2,375		20	119	119	833	24
25	Mixing valve	2005	714		20	36	36	250	25
26	Blacktop repair	2005	1,846		20	92	92	645	26
27	Blacktop repair	2005	320		20	16	16	112	27
28	Wire outside lights	2006	1,145		20	57	57	343	28
29	Plywood for Air lock ceiling	2006	123		20	6	6	36	29
30	Install entry for air lock	2006	3,935		20	197	197	1,182	30
31	Door for air lock	2006	3,028		20	151	151	907	31
32	Dining outlet	2006	155		20	8	8	48	32
33	Exhaust fan & rewire junction	2006	1,633		20	82	82	491	33
34	TOTAL (lines 1 thru 33)		\$ 1,893,447	\$ 45,784		\$ 57,594	\$ 11,810	\$ 1,178,436	34

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

Facility Name & ID Number Hallmark House Nursing Center

36343

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,893,447	\$ 45,784		\$ 57,594	\$ 11,810	\$ 1,178,436	1
2	Outlet for steamer in kitchen	2006	381		20	19	19	114	2
3	Remodeol bathroom 129	2006	508		20	25	25	151	3
4	Cabinets for bath in Rm 129	2006	946		20	47	47	283	4
5	Install sink in janitor closet	2006	1,500		20	75	75	450	5
6	Plumbing for bathroom	2006	1,350		20	68	68	407	6
7	Cabinets for bath	2006	443		20	22	22	132	7
8	Replace flooring in rm 129 bath	2006	370		20	19	19	113	8
9	New door nurses station	2006	1,314		20	66	66	395	9
10	Reroof east end	2006	4,928		20	246	246	1,477	10
11	Flooring shower room	2006	1,565		20	78	78	469	11
12	Ada door opener downpay	2006	512		20	26	26	155	12
13	Ada door opener	2006	1,536		20	77	77	462	13
14	New activity room door	2006	1,710		20	86	86	515	14
15	New carpeting	2006	11,500		20	575	575	3,450	15
16	Tile bathroom remodel	2006	371		20	19	19	113	16
17	Sidewalk	2006	243		20	12	12	72	17
18	Sidewalk in front	2006	757		20	38	38	228	18
19	Bathroom flooring Rm 114	2006	465		20	23	23	139	19
20	Cabinets for bathroom	2006	1,168		20	58	58	349	20
21	Bathroom remoded rm 114	2006	350		20	18	18	107	21
22	Plywood reroof east end	2006	1,689		20	84	84	505	22
23	Carpeting	2006	11,500		20	575	575	3,450	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	552	24
25	Doors	2007	6,052		20	303	303	1,514	25
26	Carpeting	2007	11,000		20	550	550	2,750	26
27	Tile work	2007	2,930		20	147	147	734	27
28	Hood systems to alarm	2007	1,836		20	92	92	460	28
29	Electrical work	2007	2,961		20	148	148	740	29
30	Vent air conditioner hall	2007	1,140		20	57	57	285	30
31	Folding doors	2007	4,236		20	212	212	1,060	31
32	AC Dining room	2007	5,800		20	290	290	1,450	32
33	Bathroom	2007	15,450		20	773	773	3,864	33
34	TOTAL (lines 1 thru 33)		\$ 1,991,801	\$ 45,784		\$ 62,514	\$ 16,730	\$ 1,205,381	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,991,801	\$ 45,784		\$ 62,514	\$ 16,730	\$ 1,205,381	1
2 Bathrooms for rooms 131 & 132 new construction	2008	29,726		20	1,486	1,486	5,944	2
3 Plumbing return line	2008	2,875		20	144	144	576	3
4 Boiler	2008	5,631		20	282	282	1,128	4
5 AC basement office	2008	452		20	23	23	92	5
6 SPA tile	2008	3,530		20	177	177	708	6
7 Walk in	2008	29,462		20	1,473	1,473	5,892	7
8 Heat pkg dining room	2008	301		20	15	15	60	8
9 Install fans in kitchen	2008	1,650		20	83	83	332	9
10 Install grease trap	2008	1,894		20	95	95	380	10
11 Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20	436	436	1,308	11
12 Lighting	2010	12,987		40	325	325	352	12
13 Generator	2010	48,199		10	4820	4,820	6,828	13
14 Kitchen air conditioner	2011	14,198		40	237	237	237	14
15 Heating unit	2011	3,783		40	39	39	39	15
16 Tankless water heaters (2)	2011	6,500		10	217	217	217	16
17 Roof over dining room	2011	17,885		40	410	410	410	17
18 Doors for Gazebo entrance	2011	5,018		40	105	105	105	18
19 Hallway lighting	2011	3,575		40	67	67	67	19
20 Therapy door	2011	4,470		40	75	75	75	20
21 Expansion joints repair	2011	2,806		40	23	23	23	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,195,462	\$ 45,784		\$ 73,046	\$ 27,262	\$ 1,230,152	34

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

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	\$83,171	\$7,527	\$7,680	\$153		\$74,130	71
72	Current Year Purchases	35,477	2,657	2,657			2,657	72
73	Fully Depreciated Assets	582,461					582,461	73
74								74
75	TOTALS	\$701,109	\$10,184	\$10,337	\$153		\$659,248	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Ford van	1996	\$35,576	\$	\$	\$		\$35,576	76
77	Facility	2007 Chevy G1500	2007	25,427	2,891	2,891		5	23,231	77
78	Facility	2008 Chevy HHR	2007	18,012	1,971	1,971		5	16,287	78
79										79
80	TOTALS			\$79,015	\$4,862	\$4,862	\$		\$75,094	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,032,586	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$60,830	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$88,245	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$27,415	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,964,494	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$3,694
- 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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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
		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)	\$			

- (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.

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	

- (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	1266	hrs	\$		\$ 87,887	\$ 1,182	1,266	\$ 89,069	1
2	Licensed Speech and Language Development Therapist	10a-3	150	hrs			12,013	188	150	12,201	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-3	1509	hrs			105,830	39	1,509	105,869	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	182,292					182,292	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>X-Ray</u>	39-3			6,252					6,252	12
13	Other (specify): <u></u>										13
14	TOTAL				\$ 188,544		\$ 205,730	\$ 1,409	2,925	\$ 395,683	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.

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	\$ 499,214	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,092,420		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	212,818		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,197		7
8	Accounts Receivable (owners or related parties)	289,496		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,099,145	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	853,840		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	872,518		16
17	Accumulated Depreciation (book methods)	(1,297,144)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 429,214	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,528,359	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,028	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	255,372		29
30	Accrued Salaries Payable	161,500		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,631		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,004		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Provider Participation Fee	69,118		36
37	Accrued Mgt Fees	157,530		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 830,183	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,259		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,259	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 839,442	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,688,917	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,528,359	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,646,921	1
2	Restatements (describe):		2
3	Changes in FMV investments & corrections	75,051	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,721,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,055)	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)	\$(33,055)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$1,688,917	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,476,551	1
2	Discounts and Allowances for all Levels	(39,666)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,436,885	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,929	13
14	Non-Patient Meals	127,861	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 143,790	23
	D. Non-Operating Revenue		
24	Contributions	232	24
25	Interest and Other Investment Income***	12,123	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,355	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc. Income	8,684	28
28a	Soda, Avon, Vending - see cost adjustments	10,082	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,766	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,611,796	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,064,560	31
32	Health Care	2,177,659	32
33	General Administration	751,627	33
	B. Capital Expense		
34	Ownership	362,765	34
	C. Ancillary Expense		
35	Special Cost Centers	288,240	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)*	\$ 4,644,851	40
41	Income before Income Taxes (line 30 minus line 40)**	(33,055)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (33,055)	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,664	1,732	\$51,970	\$30.01	1
2	Assistant Director of Nursing	1,944	2,112	50,688	24.00	2
3	Registered Nurses	10,972	11,605	309,372	26.66	3
4	Licensed Practical Nurses	11,232	11,681	241,942	20.71	4
5	CNAs & Orderlies	56,896	59,904	656,074	10.95	5
6	CNA Trainees	302	307	2,895	9.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,829	6,314	71,230	11.28	8
9	Activity Director	1,912	2,112	34,045	16.12	9
10	Activity Assistants	5,351	5,548	56,059	10.10	10
11	Social Service Workers	1,936	2,112	34,932	16.54	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,112	49,716	23.54	13
14	Head Cook	5,396	5,443	56,245	10.33	14
15	Cook Helpers/Assistants	10,736	10,268	94,217	9.18	15
16	Dishwashers					16
17	Maintenance Workers	3,928	4,167	55,178	13.24	17
18	Housekeepers	14,371	15,218	145,096	9.53	18
19	Laundry	4,008	4,233	37,864	8.94	19
20	Administrator	1,928	2,015	91,534	45.43	20
21	Assistant Administrator					21
22	Other Administrative	5,469	5,946	152,945	25.72	22
23	Office Manager	1,936	2,112	31,680	15.00	23
24	Clerical	4,016	4,197	71,918	17.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,849	1,960	24,031	12.26	31
32	Other Health Care(specify)	1,840	1,901	39,537	20.80	32
33	Other(specify)cosmetologist	1,768	1,848	21,592	11.68	33
34	TOTAL (lines 1 - 33)	157,227	164,847	\$2,380,760 *	\$14.44	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	123	\$5,227	3-1	35
36	Medical Director	48	6,000	9-3	36
37	Medical Records Consultant	16	1,840	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	174	6,000	10-3	39
40	Physical Therapy Consultant	292	17,355	10a-3	40
41	Occupational Therapy Consultant	268	15,975	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	285	10a-3	43
44	Activity Consultant	24	1,360	11-3	44
45	Social Service Consultant	24	1,360	12-3	45
46	Other(specify)				46
47	Psychiatrist consultant	7	2,100	10-3	47
48					48
49	TOTAL (lines 35 - 48)	981	\$57,502		49

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number	Hallmark House Nursing Center
--------------------------------------	--------------------------------------

36343

Report Period Beginning: 01/01/11

Ending: 12/31/11

Facility Name & ID Number		Hallmark House Nursing Center		STATE OF ILLINOIS	#	36343	Report Period Beginning:	01/01/11	Ending:	12/31/11	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>IHCA \$3,919 INHAA \$100</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>No</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>45,215</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u>							
(9)	Are you presently operating under a sublease agreement?			<u>YES</u> <u>X</u> <u>NO</u>							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>NO</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>78,065</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>no</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(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?			\$ <u>18,526</u> <u>no</u> Indicate the amount. \$ <u> </u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u> </u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u> </u>							
	d. Have vehicle usage logs been maintained?			<u>No</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>Yes</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>0</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Attach invoices and a summary of services for all architect and appraisal fees			<u>NA</u>							

Hallmark House Nursing Center
2011 Medicaid Cost Report
Attachments

Attachment for Page 20, line 32		
\$	39,537	Catering manager salary See adjustment on page 5A

Attachment for Page 3, line 25		
Other Administrative Staff Transportation		
Hotels and other	\$	988
Mileage for staff and consultants	\$	3,279
Total	\$	4,267

**Hallmark House
Support Schedules - Travel and Seminar
For the Year Ended December 31, 2011**

Month of Service	Name of Individuals Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Class	Cost
1/27/2011	Lynn Brady	Administrator	3/15-16/11	Springfield	Winter Conference	Illinois Nursing Home Assoc	5	\$95.00
1/27/2011	Erika Dunniway	DON	3/15-16/11	Springfield	Winter Conference	Illinois Nursing Home Assoc	5	95.00
2/1/2011	All Staff	All	Mar/Apr/May	Hallmark	Computer Training for all Mandatory Education	SliverChair Learning	4	862.96
2/24/2011	Erika Dunniway	DON	3/30-31/11	Springfield	DON Resources for Success	Illinois Health Care Assoc	5	200.00
2/25/2011	All Staff	All	2/22-24/11	Hallmark	CPR	American Red Cross	4	351.00
3/24/2011	Lynn Brady	Administrator	4/13/2011	Springfield	Regional Training	LTC Management	5	50.00
3/24/2011	Erika Dunniway	DON	4/13/2011	Springfield	Regional Training	LTC Management	5	50.00
4/8/2011	Laurie Hill	SSD	5/5 & 6/3/11	East Peoria	Social Work Best Practices	Ramirez Consulting Group	5	175.00
4/18/2011	Ruth Bowen	Administrative Assistant	6/8-9/11	East Peoria	June Conference	Illinois Nursing Home Assoc	5	95.00
4/18/2011	Jenny Cooper	Office Manager	6/8-9/11	East Peoria	June Conference	Illinois Nursing Home Assoc	5	95.00
6/1/2011	All Staff	All	Jun/Jul/Aug	Hallmark	Computer Training for all Mandatory Education	SilverChair Learning	4	862.96
6/1/2011	Donna Livengood	MDS Coordinator	6/29/2011	Naperville	MDS 3.0 in a Day!	Illinois Health Care Assoc	5	125.00
6/22/2011	Donna Livengood	MDS Coordinator	7/12-14/11	Naperville	Medicare University	Life Services Network	5	750.00
7/18/2011	Christopher Oliver	Rehab Coordinator	8/26/2011	Peoria	Therapeutic Tai Chi	Summit Professional Educati	5	179.00
7/26/2011	Lynn Brady	Administrator	8/10/2011	Bloomington	Summer Conference	Illinois Nursing Home Assoc	5	47.50
7/26/2011	Cindy Sarver	Admission/Wound Nurse	8/10-11/11	Bloomington	Summer Conference	Illinois Nursing Home Assoc	5	95.00
7/26/2011	Jay Denning	DON	8/10-11/11	Bloomington	Summer Conference	Illinois Nursing Home Assoc	5	95.00
7/26/2011	Laurie Hill	SSD	8/11/2012	Bloomington	Summer Conference	Illinois Nursing Home Assoc	5	47.50
8/1/2011	Jay Denning	DON	9/14/2011	Peoria	Innovation Breakfast	Illinois Health Care Assoc	5	30.00
8/1/2011	Katie Bloom	LPN	9/14/2011	Peoria	Innovation Breakfast/Received	Illinois Health Care Assoc	5	-
8/3/2011	Margaret Russell	Certified Nursingt Assistant Leader		Peoria	CPR Instructor Card	American Red Cross	5	19.00
8/3/2011	Margaret Russell	Certified Nursingt Assistant Leader		Peoria	First Aid Instructor Card	American Red Cross	5	19.00

**Hallmark House
Support Schedules - Travel and Seminar
For the Year Ended December 31, 2011**

8/10/2011	All Staff	all	Sep/Oct/Nov	Hallmark	Computer Training for all Mandatory	SilverChair Learning	4	862.96
8/11/2011	Margaret Russell	Certified Nursing Assistant Leader	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/11/2011	Christopher Oliver	Rehab Coordinator	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/11/2011	James Durnham	Maintenance Assistant	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/11/2011	Summer Sullins	Activity Assistant	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/11/2011	Jenny Williams	Activity Assistant	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/11/2011	Autumn Martin	Transport Certified Nursing Assistant	8/16/2011	Hallmark	Safety Venice Training	Stephanie Kastner	4	197.50
8/22/2011	Margaret Russell	Certified Nursing Assistant Leader	9/5 & 9/15/11	Peoria	CPR Instructor Class	American Red Cross	5	500.00
8/30/2011	Karen Knight	Activity Director	Sep/Oct/Nov	Hallmark	Gender Specific Planning: Men Mania	Activity Directors Network	5	24.95
8/30/2011	Karen Knight	Activity Director	Sep/Oct/Nov	Hallmark	The Importance of Marketing Your Activity Programs	Activity Directors Network	5	24.95
8/30/2011	Karen Knight	Activity Director	Sep/Oct/Nov	Hallmark	Integrating Wii Into Your Senior Program	Activity Directors Network	5	19.95
9/14/2011	Lynn Brady	Administrator	10/5/2011	East Peoria	Health Cost Containment Conference	IL Chamber of Commerce	5	129.00
9/14/2011	Ruth Bowen	Administrative Assistant	10/3/2011	East Peoria	Health Cost Containment Conference	IL Chamber of Commerce	5	129.00
9/15/2011	Deb Lang	adon	10/18/2011	Peoria	An Ostomate's Perspective on Humor and Healing	Ostomy Support Group	4	20.00
9/15/2011	Cindy Sarver	Admission/Wound Nurse	10/18/2011	Peoria	An Ostomate's Perspective on Humor and Healing	Ostomy Support Group	4	20.00
9/26/2011	All Nurses	RNs & LPNs	Sep - Dec.	Hallmark	Continuing Education	Illinois Health Care Assoc	4	725.00
9/27/2011	Lynn Brady	Administrator	11/1/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
9/27/2011	Chuck Trueblood	Food/Environmental Director	11/1/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
9/27/2011	Karen Knight	Activity Director	11/1/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
9/27/2011	Cindy Sarver	Admission/Wound Nurse	11/2/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
9/27/2011	Deb Lang	ADON	11/2/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
9/27/2011	Jay Denning	DON	11/2/2011	Springfield	Annual Convention & Trade Show	Illinois Nursing Home Assoc	4	62.50
10/3/2011	April Harris	MDS Coordinator	Oct - Dec	Hallmark	Computer MDS 3.0 Training	Healthcare Academy	5	150.00

**Hallmark House
Support Schedules - Travel and Seminar
For the Year Ended December 31, 2011**

10/5/2011	Ruth Bowen	Administrative Assistant	10/20/2011	Peoria	HIPAA/HITECH Compliance	COPS	5	10.00
10/5/2011	Jenny Cooper	Office Manager	10/20/2011	Peoria	HIPAA/HITECH Compliance	COPS	5	10.00
10/11/2011	Cheryl Carlson	Clinical Compliance	11/1/2011	Springfield	Best Prtactices in Nursing Home-Hospice Partnerships	IL-HPCO	4	140.00
10/11/2011	Laurie Hill	SSD	11/1/2011	Springfield	Best Prtactices in Nursing Home-Hospice Partnerships	IL-HPCO	4	140.00
10/13/2011	Jenny Cooper	Office Manager	12/6/2011	Normal	Part A Providers Live Event - Illinois	National Government Services	5	85.00
10/14/2011	Deb Lang	ADON	11/10/2011	East Peoria	Assessment,Prevention,Interventions	Health Professional Institute	4	129.00
10/20/2011	April Harris	MDS Coordinator	11/15/2011	Springfield	SNF PPS Final Rule & Other Medicare Challenges	Illinois Health Care Assoc	5	125.00
10/20/2011	Jenny Cooper	Office Manager	11/15/2011	Springfield	SNF PPS Final Rule & Other Medicare Challenges	Illinois Health Care Assoc	5	125.00
10/20/2011	Emily Marshall	Rehab Coordinator	10/10/2011	Galesburg	Restorative Nursing Assistant Training	AZER Seminars	4	120.00
10/27/2011	Chuck Trueblood	Food/Enviornmental Director	10/24-25/11	Manito	Food Service Sanitation Course	Workforce Health & Safety Training	5	99.00
10/27/2011	Josh Graves	Cook	10/24-25/11	Manito	Food Service Sanitation Course	Workforce Health & Safety Training	5	99.00
11/1/2011	All Staff	All	Dec/Jan/Feb	Hallmark	Computer Training for all Mandatory Education	SilverChair Learning	4	862.96
11/2/2011	Autumn Martin	Activity Assistant	11/8/2011	Springfield	Memory Loss Conference	Alzheimer's Association	4	90.00
11/2/2011	Karen Knight	Activity Director	11/8/2011	Springfield	Memory Loss Conference	Alzheimer's Association	4	90.00
11/2/2011	Jenny Williams	Activity Assistant	11/8/2011	Springfield	Memory Loss Conference	Alzheimer's Association	4	90.00
11/2/2011	Summer Sullins	Activity Assistant	11/8/2011	Springfield	Memory Loss Conference	Alzheimer's Association	4	90.00
12/28/2011	All Staff	All	11/14-15/11	Hallmark	CPR Training	American Red Cross	4	570.00
	TOTAL							\$11,379.69

Group Classification: (1) Out-of-State Travel, (2) In-State Travel, (3) Seminar Expense, (4) Education and Seminars, (5) Administrative Seminars, (6) Entertainment Expense.