

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0036343</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Hallmark House Nursing Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</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 Road</u> <u>Pekin</u> <u>61554</u>																									
Number City Zip Code																									
County: <u>Tazewell</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) See accountant's preparation report.</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>2616 Windcrest Dr., Mt. Vernon, IL 62864</u></td></tr><tr><td>(Telephone) <u>618-315-6242</u> Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) See accountant's preparation report.	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>2616 Windcrest Dr., Mt. Vernon, IL 62864</u>	(Telephone) <u>618-315-6242</u> Fax # ()												
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	(Telephone) <u>618-315-6242</u> Fax # ()																								
Date of Initial License for Current Owners: <u>5/1/90</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>618-315-6242</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number

Hallmark House Nursing Ctr

#

0036343

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,598	7,398	4,696	16,692	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,598	7,398	4,696	16,692	14

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

64.23%

SEE ACCOUNTANTS' PREPARATION REPORT

D. How many bed-hold days during this year were paid by the Department?

(Do not include bed-hold days in Section B.)

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

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

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

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 12/20/1980

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 3,602

Medicare Intermediary Ability

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	146,183	12,442	13,543	172,168		172,168		172,168			1
2	Food Purchase		91,631		91,631		91,631	(3,109)	88,522			2
3	Housekeeping	62,499	21,800		84,299		84,299		84,299			3
4	Laundry	81,052	6,546	75	87,673		87,673		87,673			4
5	Heat and Other Utilities			88,244	88,244		88,244		88,244			5
6	Maintenance	57,113	922	46,327	104,362		104,362	2,174	106,536			6
7	Other (specify):*											7
8	TOTAL General Services	346,847	133,341	148,189	628,377		628,377	(935)	627,442			8
	B. Health Care and Programs											
9	Medical Director			22,750	22,750		22,750		22,750			9
10	Nursing and Medical Records	1,116,706	96,133	28,471	1,241,310		1,241,310		1,241,310			10
10a	Therapy		646	518,361	519,007		519,007		519,007			10a
11	Activities	74,561	1,392	4,446	80,399		80,399		80,399			11
12	Social Services	44,727		1,309	46,036		46,036		46,036			12
13	CNA Training			575	575		575		575			13
14	Program Transportation			1,450	1,450		1,450		1,450			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,235,994	98,171	577,362	1,911,527		1,911,527		1,911,527			16
	C. General Administration											
17	Administrative	92,726		24,000	116,726		116,726	(24,000)	92,726			17
18	Directors Fees											18
19	Professional Services			31,325	31,325		31,325	1,500	32,825			19
20	Dues, Fees, Subscriptions & Promotions			18,085	18,085		18,085	(9,121)	8,964			20
21	Clerical & General Office Expenses	109,325		98,975	208,300		208,300	2,060	210,360			21
22	Employee Benefits & Payroll Taxes			349,361	349,361		349,361		349,361			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,264	2,264		2,264		2,264			24
25	Other Admin. Staff Transportation			5,476	5,476		5,476		5,476			25
26	Insurance-Prop.Liab.Malpractice			79,984	79,984		79,984		79,984			26
27	Other (specify):*			38,231	38,231		38,231	(38,231)				27
28	TOTAL General Administration	202,051		647,701	849,752		849,752	(67,792)	781,960			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,784,892	231,512	1,373,252	3,389,656		3,389,656	(68,727)	3,320,929			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.

SEE ACCOUNTANTS' PREPARATION REPORT

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			65,793	65,793		65,793	36,197	101,990			30
31	Amortization of Pre-Op. & Org.							1,768	1,768			31
32	Interest			8,514	8,514		8,514	36,194	44,708			32
33	Real Estate Taxes			35,210	35,210		35,210	199	35,409			33
34	Rent-Facility & Grounds			286,773	286,773		286,773	(286,773)				34
35	Rent-Equipment & Vehicles			9,433	9,433		9,433		9,433			35
36	Other (specify):*											36
37	TOTAL Ownership			405,723	405,723		405,723	(212,415)	193,308			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			148,489	148,489		148,489		148,489			39
40	Barber and Beauty Shops	11,377	337		11,714		11,714		11,714			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,541	104,541		104,541		104,541			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	11,377	337	253,030	264,744		264,744		264,744			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,796,269	231,849	2,032,005	4,060,123		4,060,123	(281,142)	3,778,981			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,813)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(38,231)	27		24
25	Fund Raising, Advertising and Promotional	(9,121)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,165)		\$	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)	(225,225)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (225,225)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (275,390)		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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjust accrual of real estate tax	\$ 199	33	1
2	Offset rebate and refund income	(296)	2	2
3	Property improvement under \$2500	2,174	6	3
4	Depreciation expense adjustment	16,171	30	4
5	To adjust management fee	(24,000)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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	(5,752)		49

Summary A

12/31/16

[illegible]

Summary B

12/31/16

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
Diane Miller	25%					
Kim Lane Trust	25%					
Leslie Miller Trust	25%					
Brandon Miller trust	25%					

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

☐ YES

☐ NO

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

1		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	\$ 286,773			\$	(286,773)	1
2	V	19	Professional fees		Pekin Professional Group		1,500	1,500	2
3	V	32	Interest		Pekin Professional Group		36,194	36,194	3
4	V	30	Depreciation		Pekin Professional Group		20,026	20,026	4
5	V	31	Amortization		Pekin Professional Group		1,768	1,768	5
6	V	21	License and Fees		Pekin Professional Group		2,060	2,060	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 286,773			\$ 61,548	\$ * (225,225)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	NA								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hallmark House Nursing Ctr # 0036343 Report Period Beginning: 1/1/16 Ending: 12/31/16

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				Mortgage			\$					\$ 36,194	1
2													2
3													3
4													4
5													5
	Working Capital												
6				Working Capital								8,514	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 44,708	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 44,708	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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 2015 report.			\$	34,813	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	35,111	2
3. Under or (over) accrual (line 2 minus line 1).			\$	298	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	35,111	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,409	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	31,490	8	
		2012	34,110	9	
		2013	34,072	10	
		2014	34,813	11	
		2015	35,111	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Ctr COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Margel S. Peddicord, CPA

TELEPHONE 618-315-6242 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 04-10-01-407-018	LTC Facility	\$ 35,110.70	\$ 35,110.70
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 35,110.70	\$ 35,110.70

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,782

B. General Construction Type: Exterior BrickFrame WoodNumber 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	LTC facility	292,455	1980	\$ 57,000	1
2					2
3	TOTALS	292,455		\$ 57,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

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			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	71		1980	1976	\$ 510,430	\$		\$ 12,761	\$ 12,761	\$ 383,054	4	
5			1980	1976	290,586			7,265	7,265	236,222	5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Building Improvements			1977	41,421	1,035			(1,035)	32,091	9	
10	Building Improvements			1978	6,473					6,473	10	
11	Building Improvements			1981	10,987	275			(275)	8,521	11	
12	Building Improvements			1982	12,368	309			(309)	9,582	12	
13	Building Improvements			1983	7,662	191			(191)	5,926	13	
14	Building Improvements			1984	2,343	58			(58)	1,802	14	
15	Building Improvements			1986	17,604	482			(482)	14,634	15	
16	Building Improvements			1987	7,275					7,275	16	
17	Building Improvements			1988	42,911					42,911	17	
18	Building Improvements			1989	15,387					15,387	18	
19	Building Improvements			1990	55,198	1,464			(1,464)	38,064	19	
20	Building Improvements			1991	11,136					11,856	20	
21	Building Improvements			1993	53,652	528			(528)	23,847	21	
22	Building Improvements			1994	45,374					45,374	22	
23	Building Improvements			1995	110,087	4,438			(4,438)	97,484	23	
24	Building Improvements			1996	26,910	450			(450)	20,226	24	
25	Building Improvements			1997	43,197					43,197	25	
26	Building Improvements			1998	118,189	5,994			(5,994)	110,890	26	
27	Building Improvements			1999	29,258	897			(897)	26,480	27	
28	Building Improvements			2000	253,531	9,642			(9,642)	169,983	28	
29	Building Improvements			2001	21,498	1,312			(1,312)	20,992	29	
30	Building Improvements			2002	22,175	(640)			640	22,175	30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

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

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

Facility Name & ID Number Hallmark House Nursing Ctr

0036343

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	\$ 1,568	37
38	Install 200 Amp Panel in Kitchen	2003	3,942		20	197	197	2,758	38
39	Install 200 Amp Panel in Kitchen	2003	1,368		20	68	68	955	39
40	Griddle Exhaust	2003	2,076		20	104	104	1,663	40
41	Circuits & Outlets	2003	2,926		20	146	146	2,046	41
42	Heater in room 116	2003	1,100		20	55	55	770	42
43	Kitchen Remodel	2003	5,967		20	298	298	4,174	43
44	Blinds	2003	833		20	42	42	586	44
45	Boiler Pump	2003	1,694		20	85	85	1,160	45
46	Boiler Repair	2003	2,247		20	112	112	1,496	46
47	Glass Doors	2003	1,602		20	80	80	1,040	47
48	Boiler	2003	1,154		20	58	58	656	48
49	Lighting	2004	610		20	31	31	401	49
50	Blinds, Valance	2004	8,175		20	409	409	5,552	50
51	Light Fixture	2004	759		20	38	38	494	51
52	Blinds & vallance	2004	9,773		20	489	489	6,589	52
53	Boiler	2004	4,586		20	229	229	2,979	53
54	Outside lighting	2004	3,155		20	158	158	2,053	54
55	Roof	2004	4,419		20	221	221	2,873	55
56	Bathroom remodel	2004	1,054		20	53	53	687	56
57	Cabinets & countertop	2004	890		20	45	45	583	57
58	Bathroom flooring	2004	546		20	27	27	353	58
59	Air conditioner	2004	3,278		20	164	164	2,132	59
60	Bathroom remodel	2004	2,000		20	100	100	1,300	60
61	Cabinets & countertop	2004	460		20	23	23	299	61
62	Cabinets in beverage centger	2004	250		20	13	13	167	62
63	Houthous	2004	7,929		20	396	396	5,150	63
64	Fire Door	2004	879		20	44	44	572	64
65	Hot water heater	2004	650		20	33	33	427	65
66	Tub repairs	2004	539		20	27	27	351	66
67	Tub repairs	2004	500		20	25	25	258	67
68	Door locks	2004	985		20	49	49	639	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,834,235	\$ 26,435		\$ 23,957	\$ (2,478)	\$ 1,447,177	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Ctr

0036343

Report Period Beginning:

1/1/16

Ending:

12/31/16

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 12A, Carried Forward		\$ 1,834,235	\$ 26,435		\$ 23,957	\$ (2,478)	\$ 1,447,177	1
2	Exhaust fan repairs	2004	717		20	36	36	468	2
3	Water heater repairs	2004	720		20	36	36	468	3
4	Plumbing repairs	2004	5,620		20	281	281	3,653	4
5	Garbage Disposals	2004	850		20	43	43	557	5
6	Storage room remodel	2004	696		20	35	35	454	6
7	Room Remodel	2004	4,496		20	225	225	2,924	7
8	Back sidewalk	2005	1,600		20	80	80	960	8
9	Fire door	2005	487		20	24	24	290	9
10	Front sidewalk	2005	1,700		20	85	85	1,020	10
11	Fire Dampers.	2005	747		20	37	37	446	11
12	Irrigation System	2005	7,750		20	388	388	4,654	12
13	Landscaping	2005	942		20	47	47	564	13
14	Landscaping	2005	6,028		20	301	301	3,611	14
15	Fish pond	2005	5,027		20	251	251	3,014	15
16	Office floor	2005	319		20	16	16	192	16
17	Walk in cooler floor	2005	800		20	40	40	480	17
18	Walk in freezer floor	2005	540		20	27	27	377	18
19	Water system pump	2005	852		20	43	43	514	19
20	Breaker panel replacement	2005	1,952		20	98	98	1,174	20
21	Public bath tile	2005	219		20	11	11	132	21
22	Wire fish pond	2005	1,016		20	51	51	612	22
23	Detectors	2005	860		20	43	43	516	23
24	Gutters	2005	2,375		20	119	119	1,428	24
25	Mixing valve	2005	714		20	36	36	430	25
26	Blacktop repair	2005	1,846		20	92	92	1,105	26
27	Blacktop repair	2005	320		20	16	16	192	27
28	Wire outside lights	2006	1,145		20	57	57	628	28
29	Plywood for Air lock ceiling	2006	123		20	6	6	66	29
30	Install entry for air lock	2006	3,935		20	197	197	2,167	30
31	Door for air lock	2006	3,028		20	151	151	1,662	31
32	Dining outlet	2006	155		20	8	8	88	32
33	Exhaust fan & rewire junction	2006	1,633		20	82	82	901	33
34	TOTAL (lines 1 thru 33)		\$ 1,893,447	\$ 26,435		\$ 26,919	\$ 484	\$ 1,482,924	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Ctr

0036343

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	\$ 26,435		\$ 26,919	\$ 484	\$ 1,482,924	1
2	Outlet for steamer in kitchen	2006	381		20	19	19	209	2
3	Remodeol bathroom 129	2006	508		20	25	25	276	3
4	Cabinets for bath in Rm 129	2006	946		20	47	47	518	4
5	Install sink in janitor closet	2006	1,500		20	75	75	825	5
6	Plumbing for bathroom	2006	1,350		20	68	68	747	6
7	Cabinets for bath	2006	443		20	22	22	242	7
8	Replace flooring in rm 129 bath	2006	370		20	19	19	208	8
9	New door nurses station	2006	1,314		20	66	66	725	9
10	Reroof east end	2006	4,928		20	246	246	2,707	10
11	Flooring shower room	2006	1,565		20	78	78	859	11
12	Ada door opener downpay	2006	512		20	26	26	285	12
13	Ada door opener	2006	1,536		20	77	77	847	13
14	New activity room door	2006	1,710		20	86	86	945	14
15	New carpeting	2006	11,500		20	575	575	6,325	15
16	Tile bathroom remodel	2006	371		20	19	19	208	16
17	Sidewalk	2006	243		20	12	12	132	17
18	Sidewalk in front	2006	757		20	38	38	418	18
19	Bathroom flooring Rm 114	2006	465		20	23	23	254	19
20	Cabinets for bathroom	2006	1,168		20	58	58	639	20
21	Bathroom remoded rm 114	2006	350		20	18	18	197	21
22	Plywood reroof east end	2006	1,689		20	84	84	925	22
23	Carpeting	2006	11,500		20	575	575	6,325	23
24	Install exit signs for LSC survey	2006	1,843		20	92	92	1,012	24
25	Doors	2007	6,052		20	303	303	3,029	25
26	Carpeting	2007	11,000		20	550	550	5,500	26
27	Tile work	2007	2,930		20	147	147	1,469	27
28	Hood systems to alarm	2007	1,836		20	92	92	920	28
29	Electrical work	2007	2,961		20	148	148	1,480	29
30	Vent air conditioner hall	2007	1,140		20	57	57	570	30
31	Folding doors	2007	4,236		20	212	212	2,120	31
32	AC Dining room	2007	5,800		20	290	290	2,900	32
33	Bathroom	2007	15,450		20	773	773	7,729	33
34	TOTAL (lines 1 thru 33)		\$ 1,991,801	\$ 26,435		\$ 31,839	\$ 5,404	\$ 1,534,469	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Hallmark House Nursing Ctr

0036343

Report Period Beginning:

1/1/16

Ending:

12/31/16

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 12C, Carried Forward		\$ 1,991,801	\$ 26,435		\$ 31,839	\$ 5,404	\$ 1,534,469	1
2	Bathrooms for rooms 131 & 132 new construction	2008	29,726		20	1,486	1,486	13,374	2
3	Plumbing return line	2008	2,875		20	144	144	1,296	3
4	Boiler	2008	5,631		20	282	282	2,538	4
5	AC basement office	2008	452		20	23	23	207	5
6	SPA tile	2008	3,530		20	177	177	1,593	6
7	Walk in	2008	29,462		20	1,473	1,473	13,257	7
8	Heat pkg dining room	2008	301		20	15	15	135	8
9	Install fans in kitchen	2008	1,650		20	83	83	747	9
10	Install grease trap	2008	1,894		20	95	95	855	10
11	Kitchen: walk-in sprinkler, wiring, duct line, ceiling & lighting	2009	8,719		20	436	436	3,488	11
12	Lighting	2010	12,987		40	325	325	1,977	12
13	Generator	2010	48,199		10	4,820	4,820	30,928	13
14	Kitchen air conditioner	2011	14,198		40	355	355	2,012	14
15	Heating unit	2011	3,783		40	95	95	514	15
16	Tankless water heaters (2)	2011	6,500		10	650	650	3,467	16
17	Roof over dining room	2011	17,885		40	447	447	2,645	17
18	Doors for Gazebo entrance	2011	5,018		40	125	125	730	18
19	Hallway lighting	2011	3,575		40	89	89	512	19
20	Therapy door	2011	4,470		40	112	112	635	20
21	Expansion joints repair	2011	2,806		40	70	70	373	21
22	Roof on Admin . Bldg.	2012	15,456		20	773	773	5,411	22
23	Sidewalks in front of facility	2012	8,850		20	443	443	3,099	23
24	Boiler	2012	16,885		20	844	844	5,910	24
25	Parking lot expansion	2013	49,995		20	2,500	2,500	8,750	25
26	Dining room remodel	2013	5,689		40	142	142	497	26
27	Fire system upgrade	2013	6,347		10	635	635	2,222	27
28	Air Conditioner Unit	2015	8,860		39	227	227	341	28
29	Indoor/OH Sprinkler System	2015	8,520		39	218	218	327	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,316,064	\$ 26,435		\$ 48,921	\$ 22,486	\$ 1,642,307	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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 12D, Carried Forward		\$2,316,064	\$26,435		\$48,921	\$22,486	\$1,642,307	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	TOTAL (lines 1 thru 33)		\$2,316,064	\$26,435		\$48,921	\$22,486	\$1,642,307	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$380,236	\$	\$39,857	\$39,857		\$211,344	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	582,461					582,461	73
74								74
75	TOTALS	\$962,697	\$	\$39,857	\$39,857		\$793,805	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Van 2016	2016	\$47,195	\$	\$4,720	\$4,720		\$4,720	76
77	Facility	2007 Chevy HHR	2007	18,012					18,012	77
78	Facility	2015 Ford Explorer	2015	42,459		8,492	8,492		12,738	78
79										79
80	TOTALS			\$107,666	\$	\$13,212	\$13,212		\$35,470	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,443,427	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$26,435	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$101,990	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$75,555	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,471,582	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: \$9,433
- 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.

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
		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 237,477		\$	\$		\$ 237,477	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs	18,581					18,581	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs	262,304					262,304	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts	148,489					148,489	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 666,851		\$	\$		\$ 666,851	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 712,488	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	653,539		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	19,422		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	72,901		7
8	Accounts Receivable (owners or related parties)	6,234		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,464,584	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	906,995		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,070,367		16
17	Accumulated Depreciation (book methods)	(1,484,863)		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)	\$ 492,499	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,957,083	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 192,719	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,049		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,331		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,704		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 318,803	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,283		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)	\$ 78,283	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 397,086	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,559,997	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,957,083	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,541,149	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,541,149	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	225,308	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	(168,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Correction	(38,460)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 18,848	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)	\$ 1,559,997	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hallmark House Nursing Ctr

0036343

Report Period Beginning: 1/1/16

Ending: 12/31/16

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,016,147	1
2	Discounts and Allowances for all Levels	(2,446,506)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,569,641	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	647,310	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 647,310	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	9,821	13
14	Non-Patient Meals	2,813	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,798	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,419	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,851	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	242	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 242	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebates, refunds & other--see adjustments	12,387	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,387	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,285,431	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	628,377	31
32	Health Care	1,911,527	32
33	General Administration	849,752	33
	B. Capital Expense		
34	Ownership	405,723	34
	C. Ancillary Expense		
35	Special Cost Centers	160,203	35
36	Provider Participation Fee	104,541	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,060,123	40
41	Income before Income Taxes (line 30 minus line 40)**	225,308	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 225,308	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,117,301	44
45	Private Pay - Net Inpatient Revenue	1,437,626	45
46	Medicare - Net Inpatient Revenue	1,014,714	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,569,641	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,948	2,042	\$ 69,795	\$ 34.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,592	11,065	260,169	23.51	3
4	Licensed Practical Nurses	12,142	12,589	323,657	25.71	4
5	CNAs & Orderlies	45,296	46,717	521,803	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,086	28,573	13.70	9
10	Activity Assistants	1,194	1,201	46,037	38.33	10
11	Social Service Workers	3,974	4,151	51,778	12.47	11
12	Dietician					12
13	Food Service Supervisor	2,563	2,797	39,722	14.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,428	10,751	106,475	9.90	15
16	Dishwashers					16
17	Maintenance Workers	2,379	2,503	57,113	22.82	17
18	Housekeepers	7,961	8,221	95,641	11.63	18
19	Laundry	5,107	5,263	47,910	9.10	19
20	Administrator	1,940	2,088	85,785	41.08	20
21	Assistant Administrator	184	184	6,015	32.69	21
22	Other Administrative					22
23	Office Manager	1,984	2,088	46,425	22.23	23
24	Clerical	585	609	14,359	23.58	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	1,888	2,016	29,149	14.46	31
32	Other Health Care(specify)					32
33	Other(specify)Cosmetologist	728	755	11,828	15.67	33
34	TOTAL (lines 1 - 33)	112,867	117,126	\$ 1,842,234 *	\$ 15.73	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		\$ 7,332	1-3	35
36	Medical Director		22,750	9-3	36
37	Medical Records Consultant		2,080	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,250	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,309	11-3	44
45	Social Service Consultant		1,309	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,030		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

INHAA \$100

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$15,997

Line

10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(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.

\$104,541

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 benefit on Schedule V.

\$NA

Has any meal income been offset against related costs?

NA

Indicate the amount.

\$NA

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

NA

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$NA

(17) Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

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

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.

NA

Attach invoices and a summary of services for all architect and appraisal fees
- SEE ACCOUNTANTS' PREPARATION REPORT

**Support Schedules - Travel and Seminar
Hallmark House 2016**

Month of Service	Name of Individuals Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Classification	Cost
September	Laurie Read	Administrator	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Debbie McDonald	Business Office Mgr	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Heather Fischer	Dietary Supervisor	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Troy Jensen	Maintenance Sprv	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Tiffany Vaugh	Wound/Restorative Nurse	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Katie Henderson	Asst Administrator	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Cheryl Carlson	MDS/Care Plan Nurse	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Sara Garber	Housekeeping/Laundry	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Ivy Dison	Activity Director	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Jason Gibbs	Director of Nursing	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Rissa Satterlee	Medical Records	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
September	Rachel Grace	Social Service Director/Marketing	9/13-9/15/2016	Peoria, IL	IHCA Convention	Illinois Health Care Assoc.		\$103.75
May	Tiffany Vaugh	Wound/Restorative Nurse	5/5/2016	on line	Skin & Wound Mgmt	care education institute		\$800.00
						Other		\$219.00
								.
						Total		\$2,264.00

Hallmark House, Pekin
2016 Medicaid Cost Report
Attachment for Schedule V line 25
Other administrative staff staff transportation

Fuel purchaes for facility owned vehicles	\$	4,955
Mileage paid for use of employee vehicles		<u>521</u>
Total	\$	<u><u>5,476</u></u>