

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

<p>I. IDPH License ID Number: <u>0045542</u></p> <p>Facility Name: <u>Marklund Haverkamp Home</u></p> <p>Address: <u>1 South 394 Wyatt Dr</u> <u>Geneva</u> <u>60134</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(630) 593-5500</u> Fax # <u>(630) 593-5501</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>09/02/03</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/13</u> to <u>06/30/14</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Gilbert W. Fonger</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President/ CEO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Gilbert W. Fonger</u>			(Title) <u>President/ CEO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____ Fax # () _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Firm Name & Address) _____																																									
	(Telephone) () _____ Fax # () _____																																									
<p>In the event there are further questions about this report, please contact: Name: <u>Lynn Melvin</u> Telephone Number: <u>(630) 593-5485</u> Email Address: _____</p>	<p>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</p>																																									

Facility Name & ID Number Marklund Haverkampf Home

0045542 Report Period Beginning: 07/01/13 Ending: 06/30/14

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,824	0	0	5,824	13
14	TOTALS	5,824			5,824	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.73%

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

5 (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)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 10/20/03

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/14 Fiscal Year: 06/30/14

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

Facility Name & ID Number

Marklund Haverkamp Home

0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	31,601	1,322	3,277	36,200		36,200	36,200			1
2	Food Purchase		43,744		43,744		43,744	43,744			2
3	Housekeeping	13,936	6,730	1,732	22,398		22,398	22,398			3
4	Laundry	13,253	2,637		15,890		15,890	15,890			4
5	Heat and Other Utilities			28,204	28,204		28,204	28,204			5
6	Maintenance	12,240	3,658	20,256	36,154		36,154	36,154			6
7	Other (specify):* Disposal Services			1,840	1,840		1,840	1,840			7
8	TOTAL General Services	71,030	58,091	55,309	184,430		184,430	184,430			8
	B. Health Care and Programs										
9	Medical Director			4,354	4,354		4,354	4,354			9
10	Nursing and Medical Records	656,592	37,468	13,031	707,091		707,091	707,091			10
10a	Therapy	89,677	527	548	90,752		90,752	90,752			10a
11	Activities	41,991	5,306		47,297		47,297	47,297			11
12	Social Services	4,329			4,329		4,329	4,329			12
13	CNA Training										13
14	Program Transportation	6,427		16,033	22,460		22,460	22,460			14
15	Other (specify):* Vision, Dental, Pharmacy & Psych consultants			2,796	2,796		2,796	2,796			15
16	TOTAL Health Care and Programs	799,016	43,301	36,762	879,079		879,079	879,079			16
	C. General Administration										
17	Administrative	26,975			26,975		26,975	26,975			17
18	Directors Fees										18
19	Professional Services			3,788	3,788		3,788	3,788			19
20	Dues, Fees, Subscriptions & Promotions			8,935	8,935		8,935	(3,407)	5,528		20
21	Clerical & General Office Expenses	26,795	25,143	6,037	57,975	(5,916)	52,059	52,059			21
22	Employee Benefits & Payroll Taxes			184,233	184,233		184,233	184,233			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,887	2,887		2,887	(2,887)			24
25	Other Admin. Staff Transportation			3,723	3,723		3,723	(3,723)			25
26	Insurance-Prop.Liab.Malpractice			25,143	25,143		25,143	25,143			26
27	Other (specify):* fundraising/promotional			1,667	1,667		1,667	(1,667)			27
28	TOTAL General Administration	53,770	25,143	236,413	315,326	(5,916)	309,410	(11,684)	297,726		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	923,816	126,535	328,484	1,378,835	(5,916)	1,372,919	(11,684)	1,361,235		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Haverkampf Home

#0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			97,920	97,920		97,920	(2,537)	95,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			284	284		284	(284)				32
33	Real Estate Taxes			23	23		23	(23)				33
34	Rent-Facility & Grounds			8,556	8,556		8,556	(8,556)				34
35	Rent-Equipment & Vehicles					5,916	5,916		5,916			35
36	Other (specify):*											36
37	TOTAL Ownership			106,783	106,783	5,916	112,699	(11,400)	101,299			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,943	77,943		77,943		77,943			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			77,943	77,943		77,943		77,943			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	923,816	126,535	513,210	1,563,561		1,563,561	(23,084)	1,540,477			45

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

Facility Name & ID Number Marklund Haverkamp Home

0045542

Report Period Beginning: 07/01/13

Ending: 06/30/14

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				9
10	Interest and Other Investment Income	(284)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,407)	20		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	(1,667)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(17,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,084)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (23,084)		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	2	3	4	
		Yes	No	Amount	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

Marklund Haverkamp Home

ID# 0045542

Report Period Beginning: 07/01/13

Ending: 06/30/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Seminars	\$ (2,887)	24	1
2	Travel & Sustenance	(3,723)	25	2
3	Depreciation	(2,537)	30	3
4	Real Estate Taxes	(23)	33	4
5	Rent	(8,556)	34	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(17,726)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Haverkamp Home# 0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,407)	0	0	0	0	0	0	0	0	0	0	(3,407)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,887)	0	0	0	0	0	0	0	0	0	0	(2,887)	24
25	Other Admin. Staff Transportation	(3,723)	0	0	0	0	0	0	0	0	0	0	(3,723)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	27
28	TOTAL General Administration	(11,684)	0	0	0	0	0	0	0	0	0	0	(11,684)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,684)	0	0	0	0	0	0	0	0	0	0	(11,684)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Haverkamp Home# 0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,537)	0	0	0	0	0	0	0	0	0	0	(2,537)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(284)	0	0	0	0	0	0	0	0	0	0	(284)	32
33	Real Estate Taxes	(23)	0	0	0	0	0	0	0	0	0	0	(23)	33
34	Rent-Facility & Grounds	(8,556)	0	0	0	0	0	0	0	0	0	0	(8,556)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(11,400)	0	0	0	0	0	0	0	0	0	0	(11,400)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(23,084)	0	0	0	0	0	0	0	0	0	0	(23,084)	45

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
N/A						

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
1	V			\$				\$	\$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$				\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

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

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

Facility Name & ID Number Marklund Haverkamp Home

0045542

Report Period Beginning:

07/01/13

Ending: 06/30/14

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

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1	Dietary	Direct Cost Budget	15,060,316	15,060,316	\$ 24	\$ 1,342,235	\$ 2	1
2	2	Food	Direct Cost Budget	15,060,316	15,060,316	477	1,342,235	42	2
3	3	Housekeeping	Direct Cost Budget	15,060,316	15,060,316	5,114	1,342,235	456	3
4	5	Utilities	Direct Cost Budget	15,060,316	15,060,316	52,009	1,342,235	4,635	4
5	6	Maintenance	Direct Cost Budget	15,060,316	15,060,316	24,374	1,342,235	2,172	5
6	7	Disposal	Direct Cost Budget	15,060,316	15,060,316	3,605	1,342,235	321	6
7	13	BNATP	Direct Cost Budget	15,060,316	15,060,316	0	1,342,235	0	7
8	14	Transportation	Direct Cost Budget	15,060,316	15,060,316	6,522	1,342,235	581	8
9	19	Professional Services	Direct Cost Budget	15,060,316	15,060,316	35,004	1,342,235	3,120	9
10	20	Fees,Subscription	Direct Cost Budget	15,060,316	15,060,316	52,260	1,342,235	4,658	10
11	21	Clerical/Office	Direct Cost Budget	15,060,316	15,060,316	173,142	1,342,235	15,431	11
12	22	Benefits	Direct Cost Budget	15,060,316	15,060,316	76,019	1,342,235	6,775	12
13	24	Travel & Seminar	Direct Cost Budget	15,060,316	15,060,316	16,881	1,342,235	1,505	13
14	25	Staff Transportation	Direct Cost Budget	15,060,316	15,060,316	10,283	1,342,235	916	14
15	26	Insurance	Direct Cost Budget	15,060,316	15,060,316	20,177	1,342,235	1,798	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 475,891	\$	\$ 42,412	25

Facility Name & ID Number

Marklund Haverkamp Home

0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	N/A						\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	N/A															
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
B. Non-Facility Related*																
10	N/A															
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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 2013 report.		\$ <u>N/A</u>	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.)		\$	2	
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>#VALUE!</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$ <u>#VALUE!</u>	7	
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY	
	2010 _____	9		
	2011 _____	10		
	2012 _____	11		
	2013 _____	12		
		13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Haverkampf Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045542

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

TELEPHONE (630) 593-5487 FAX #: (630) 593-5501

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>11-24-191-005</u>	<u>Residential - Tax exempt</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Marklund Haverkamp Home

0045542 Report Period Beginning:

07/01/13 Ending:

06/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,315 B. General Construction Type: Exterior Brick/Cedar Frame Wood/Steel 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).

<u>Marklund Hyde Center</u>	<u>Day Training</u>	<u>43,000 Square Feet</u>	<u>112 Person Capacity</u>
<u>Marklund Vandermolen Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Sayers Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Tommy Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Mill Creek Home 3</u>	<u>16-Bed Facility</u>	<u>8,815 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Richard Home</u>	<u>16-Bed Facility</u>	<u>8,815 Square Feet</u>	<u>16 Person Capacity</u>

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
	<u>1 Patient Care</u>	<u>35,195</u>	<u>1999</u>	<u>\$ 166,636</u>	<u>1</u>
	<u>2</u>				<u>2</u>
	<u>3 TOTALS</u>	<u>35,195</u>		<u>\$ 166,636</u>	<u>3</u>

Facility Name & ID Number Marklund Haverkamp Home

0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	16		2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264	\$	\$ 643,268	4
5			2003	2003	39,997	2,000	10	2,000		39,997	5
6											6
7											7
8											8
		Improvement Type**									
9		BI Electrical Upgrade	2003		3,222		5			3,222	9
10		BI Gutter Installation	2004		383		5			383	10
11		BI Emergency Battery Lights - Generator	2005		333	33	10	33		316	11
12		LI Sealcoating driveway and paths	2005		1,712		2			1,712	12
13		LI Grading and seeding of land parcel	2005		301		5			301	13
14		LI Bollard Lighting	2005		1,300		5			1,300	14
15		LI Concrete slabs by dumpsters	2006		1,950		5			1,950	15
16		LI Custom exterior signage	2006		1,227		5			1,227	16
17		BI Mecho Shades	2008		2,118		5			2,118	17
18		BI Lightning Protection System	2008		3,100		5			3,100	18
19		BI Tile Installation Under Cabinets	2008		771		5			771	19
20		LI Hot Rubber Crackfill Repair	2008		427		2			427	20
21		LI Sealcoating Driveway/Sidewalks	2008		1,525		2			1,525	21
22		LI Installation of 2 Bollard Lights	2009		637	64	5	64		637	22
23		BI Epoxy Bathroom Floors	2009		5,858	586	5	586		5,858	23
24		BI Oak Plywood Shelving	2009		1,045	105	5	105		1,045	24
25		LI Replacement dumpster gate	2010		166	33	5	33		149	25
26		BI Wall carpet, Corian Base Oak trim	2010		26,705	5,341	5	5,341		24,035	26
27		LI Asphalt Repairs North Approach to NE Parking Lot	2011		1,217	243	5	243		852	27
28		LI Replacement Asphalt Sidewalks W/ Concrete	2011		4,501	450	10	450		1,575	28
29		LI Replacement Asphalt Sidewalks W/ Concrete	2011		4,667	467	10	467		1,633	29
30		BI Gutter Extension Over Patio	2012		423	85	5	85		211	30
31		LI Refurbishig of Exterior Signs	2012		1,664	333	5	333	0	832	31
32		LI Asphalt Repairs (split between homes)	2012		163	33	5	33		81	32
33		LI Replacement of Wood Posts - Generator	2012		483	97	5	97		241	33
34		LI Wheelchair Glider W/ Concrete Pad (Split all homes)	2013		1,562	312	5	312		469	34
35		BI Removal & Replacement of Carpet/4" Base	2014		35,250	3,525	5	3,525		3,525	35
36		LI Concrete Replacement of Asphalt Sidewalk	2014		2,833	142	10	142		142	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

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	\$ 49,618	\$ 9,101	\$ 9,101	\$	5	\$ 27,781	71
72	Current Year Purchases	18,370	1,849	1,849		5	1,849	72
73	Fully Depreciated Assets	106,611					106,611	73
74								74
75	TOTALS	\$ 174,599	\$ 10,950	\$ 10,950	\$		\$ 136,240	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	Patient Transport	2012 Ford Mobility Van	2012	\$ 34,510	\$ 6,902	\$ 6,902	\$	5	\$ 17,255	76
77	Snow Plow Truck (1/6)	2012 Ford F-350 (1/6)	2012	7,517	1,503	1,503		5	3,758	77
78	Maintenance	2013 Ford SD Truck (1/6)	2013	4,586	917	917		5	1,376	78
79	Laundry Van/General Use	2008 Ford Cargo Van (1/6)	2008	3,563				5	3,563	79
80	TOTALS			\$ 50,176	\$ 9,322	\$ 9,322	\$		\$ 25,952	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,762,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,383	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,383	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 905,094	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marklund Haverkamp Home

0045542

Report Period Beginning: 07/01/13

Ending: 06/30/14

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 5,916 Description: Office Equipment/Machinery

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Marklund Haverkampf Home # 0045542 Report Period Beginning: 07/01/13 Ending: 06/30/14
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							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			\$		\$	\$		\$	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.

Facility Name & ID Number Marklund Haverkamp Home# 0045542Report Period Beginning: 07/01/13

Ending:

06/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/14

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,563,117	\$ 1,563,117	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>221,500</u>)	2,374,573	2,374,573	3
4	Supply Inventory (priced at)	46,832	46,832	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	122,606	122,606	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	691,633	691,633	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,798,761	\$ 4,798,761	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,400,860	6,400,860	13
14	Buildings, at Historical Cost	21,823,879	21,823,879	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,067,270	5,067,270	16
17	Accumulated Depreciation (book methods)	(18,640,365)	(18,640,365)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,604,612	10,604,612	21
22	Other Long-Term Assets (specify):	6,280,789	6,280,789	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,537,045	\$ 31,537,045	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 36,335,806	\$ 36,335,806	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 354,829	\$ 354,829	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	250,000	250,000	29
30	Accrued Salaries Payable	213,939	213,939	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,023	17,023	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>compensation & related payables</u>	517,204	517,204	36
37	<u>misc. other</u>	2,027,880	2,027,880	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,380,875	\$ 3,380,875	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,380,875	\$ 3,380,875	46
47	TOTAL EQUITY (page 18, line 24)	\$ 32,954,931	\$ 32,954,931	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 36,335,806	\$ 36,335,806	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 29,047,572	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 29,047,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,958)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,799,859	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) <u>Remaining Consolidated Income</u>	(469,111)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,132,790	17
	B. Transfers (Itemize):		
18	<u>Transfers out of Restricted Funds into Operations- exp.</u>	(225,431)	18
19	<u>Transfers out of Restricted Funds into Operations-capital</u>	(364,502)	19
20	<u>Transfers into Operations from Restricted Funds</u>	364,502	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (225,431)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 32,954,931	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.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$	1,310,592	1
2	Discounts and Allowances for all Levels	(2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	1,310,592	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			13
14	Non-Patient Meals		439	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)	\$	439	23
D. Non-Operating Revenue				
24	Contributions		54,572	24
25	Interest and Other Investment Income***			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	54,572	26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	1,365,603	30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services		184,430	31
32	Health Care		879,079	32
33	General Administration		315,326	33
B. Capital Expense				
34	Ownership		106,783	34
C. Ancillary Expense				
35	Special Cost Centers			35
36	Provider Participation Fee		77,943	36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	1,563,561	40
41	Income before Income Taxes (line 30 minus line 40)**		(197,958)	41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	(197,958)	43

III. Net Inpatient Revenue detailed by Payer Source				
44	Medicaid - Net Inpatient Revenue	\$	1,219,362	44
45	Private Pay - Net Inpatient Revenue			45
46	Medicare - Net Inpatient Revenue			46
47	Other-(specify) <u>SSA</u>		91,230	47
48	Other-(specify)			48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	1,310,592	49

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

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

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

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

Facility Name & ID Number Marklund Haverkamp Home

0045542

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	276	291	\$ 12,539	\$ 43.09	1
2	Assistant Director of Nursing	652	686	20,365	29.67	2
3	Registered Nurses	6,481	6,822	206,544	30.28	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	25,352	26,686	378,413	14.18	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	2,035	2,142	85,396	39.87	7
8	Rehab/Therapy Aides	276	291	4,281	14.71	8
9	Activity Director	316	333	6,992	21.00	9
10	Activity Assistants	2,430	2,558	34,999	13.68	10
11	Social Service Workers	257	270	4,329	16.03	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	652	686	19,247	28.06	13
14	Head Cook	336	354	5,711	16.13	14
15	Cook Helpers/Assistants	336	354	3,462	9.78	15
16	Dishwashers	336	354	3,182	8.99	16
17	Maintenance Workers	633	666	12,240	18.38	17
18	Housekeepers	1,324	1,394	13,936	10.00	18
19	Laundry	1,324	1,394	13,253	9.51	19
20	Administrator	336	354	16,442	46.45	20
21	Assistant Administrator	316	333	10,533	31.63	21
22	Other Administrative	336	354	20,003	56.51	22
23	Office Manager	0	0	0		23
24	Clerical	415	437	6,792	15.54	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,976	2,080	34,944	16.80	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	276	291	3,786	13.01	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	47,165	49,650	\$ 923,816 *	\$ 18.61	34

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

** See instructions.

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	29	\$ 1,433	1	35
36	Medical Director	monthly	4,354	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	154	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	548	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	19	1,594	15	46
47	<u>Vision</u>	11	248	15	47
48	<u>Dental</u>	32	800	15	48
49	TOTAL (lines 35 - 48)	106	\$ 9,131		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	36	\$ 1,630	10	50
51	Licensed Practical Nurses	0	0	10	51
52	Certified Nurse Assistants/Aides	500	11,401	10	52
53	TOTAL (lines 50 - 52)	536	\$ 13,031		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Marklund Haverkamp Home# 0045542Report Period Beginning: 07/01/13Ending: 06/30/14**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. Illinois Healthcare Association, \$883
- (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? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,595 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. \$ 77,943
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? Yes,Sch.8 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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	BizHub 28:	1

