FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 0047258

Facility Name: Marklund Mill Creek 3

Address: 1 South 381 Wyatt Dr (Number) Geneva (City) 60134 (Zip Code)

County: Kane

Telephone Number: (630) 593-5500 **Fax #** (630) 593-5501

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

IRS Exemption Code 501 (c) 3

In the event there are further questions about this report, please contact:
Name: Lynn Melvin **Telephone Number:** (630)593-5485
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/14 to 06/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Gilbert W. Fonger
(Title) President/ CEO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,791			5,791	13
14	TOTALS	5,791			5,791	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.16%

D. How many bed-hold days during this year were paid by the Department?
16 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 06/16/06

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/15 Fiscal Year: 06/30/15

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

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	32,636	1,553	4,777	38,966		38,966		38,966			1
2	Food Purchase		42,815		42,815		42,815		42,815			2
3	Housekeeping	15,469	6,698	625	22,792		22,792		22,792			3
4	Laundry	13,253	2,529		15,782		15,782		15,782			4
5	Heat and Other Utilities			27,863	27,863		27,863		27,863			5
6	Maintenance	19,522	4,955	16,437	40,914		40,914		40,914			6
7	Other (specify):* Disposal Services			1,887	1,887		1,887		1,887			7
8	TOTAL General Services	80,880	58,550	51,589	191,019		191,019		191,019			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	681,748	35,995	31,593	749,336		749,336		749,336			10
10a	Therapy	85,310	359	408	86,077		86,077		86,077			10a
11	Activities	37,441	5,237		42,678		42,678		42,678			11
12	Social Services	4,329			4,329		4,329		4,329			12
13	CNA Training											13
14	Program Transportation	6,427		16,028	22,455		22,455		22,455			14
15	Other (specify):* Vision, Dental,Pharmacy & Pysch consultants			2,692	2,692		2,692		2,692			15
16	TOTAL Health Care and Programs	815,255	41,591	54,721	911,567		911,567		911,567			16
	C. General Administration											
17	Administrative	27,192			27,192		27,192		27,192			17
18	Directors Fees											18
19	Professional Services			5,308	5,308		5,308		5,308			19
20	Dues, Fees, Subscriptions & Promotions			9,213	9,213		9,213	(3,081)	6,132			20
21	Clerical & General Office Expenses	28,486	24,467	4,753	57,706	(3,494)	54,212		54,212			21
22	Employee Benefits & Payroll Taxes			204,111	204,111		204,111		204,111			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,478	2,478		2,478	(2,478)				24
25	Other Admin. Staff Transportation			2,435	2,435		2,435	(2,435)				25
26	Insurance-Prop.Liab.Malpractice			25,668	25,668		25,668		25,668			26
27	Other (specify):*			1,667	1,667		1,667	(1,667)				27
28	TOTAL General Administration	55,678	24,467	255,633	335,778	(3,494)	332,284	(9,661)	322,623			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	951,813	124,608	361,943	1,438,364	(3,494)	1,434,870	(9,661)	1,425,209			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 Mill Creek 3 #0047258 **Report Period Beginning:** 07/01/14 **Ending:** 06/30/15

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			123,475	123,475		123,475	(9,943)	113,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,641	1,641		1,641	(1,641)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			8,537	8,537		8,537	(8,537)				34
35	Rent-Equipment & Vehicles					3,494	3,494		3,494			35
36	Other (specify):*											36
37	**TOTAL Ownership**			133,653	133,653	3,494	137,147	(20,121)	117,026			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			77,641	77,641		77,641		77,641			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			77,641	77,641		77,641		77,641			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	951,813	124,608	573,237	1,649,658		1,649,658	(29,782)	1,619,876			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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,641)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,081)	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	(23,393)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,782)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (29,782)		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

Marklund Mill Creek 3

ID# 0047258

Report Period Beginning: 07/01/14

Ending: 06/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (2,478)	24	1
2	Travel & Sustenance	(2,435)	25	2
3	Depreciation	(9,943)	30	3
4	Real Estate Taxes	0	33	4
5	Rent	(8,537)	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**	(23,393)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Mill Creek 3 **#** 0047258 **Report Period Beginning:** 07/01/14 **Ending:** 06/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	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	(3,081)	0	0	0	0	0	0	0	0	0	0	(3,081)	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	(2,478)	0	0	0	0	0	0	0	0	0	0	(2,478)	24
25	Other Admin. Staff Transportation	(2,435)	0	0	0	0	0	0	0	0	0	0	(2,435)	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**	(9,661)	0	0	0	0	0	0	0	0	0	0	(9,661)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,661)	0	0	0	0	0	0	0	0	0	0	(9,661)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 **Report Period Beginning:** 07/01/14 **Ending:** 06/30/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(9,943)	0	0	0	0	0	0	0	0	0	0	(9,943)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,641)	0	0	0	0	0	0	0	0	0	0	(1,641)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(8,537)	0	0	0	0	0	0	0	0	0	0	(8,537)	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**	(20,121)	0	0	0	0	0	0	0	0	0	0	(20,121)	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,782)	0	0	0	0	0	0	0	0	0	0	(29,782)	45

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	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.**

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	15,635,353	15,635,353	$ 53	$	1,383,266	$ 5	1
2	2	Food	Direct Cost Budget	15,635,353	15,635,353	737		1,383,266	65	2
3	3	Housekeeping	Direct Cost Budget	15,635,353	15,635,353	4,211		1,383,266	373	3
4	5	Utilities	Direct Cost Budget	15,635,353	15,635,353	52,857		1,383,266	4,676	4
5	6	Maintenance	Direct Cost Budget	15,635,353	15,635,353	16,478		1,383,266	1,458	5
6	7	Disposal	Direct Cost Budget	15,635,353	15,635,353	3,664		1,383,266	324	6
7	13	BNATP	Direct Cost Budget	15,635,353	15,635,353	0		1,383,266	0	7
8	14	Transportation	Direct Cost Budget	15,635,353	15,635,353	6,522		1,383,266	577	8
9	19	Professional Services	Direct Cost Budget	15,635,353	15,635,353	48,000		1,383,266	4,247	9
10	20	Fees,Subscription	Direct Cost Budget	15,635,353	15,635,353	56,431		1,383,266	4,992	10
11	21	Clerical/Office	Direct Cost Budget	15,635,353	15,635,353	172,201		1,383,266	15,235	11
12	22	Benefits	Direct Cost Budget	15,635,353	15,635,353	89,292		1,383,266	7,900	12
13	24	Travel & Seminar	Direct Cost Budget	15,635,353	15,635,353	8,920		1,383,266	789	13
14	25	Staff Transportation	Direct Cost Budget	15,635,353	15,635,353	10,512		1,383,266	930	14
15	26	Insurance	Direct Cost Budget	15,635,353	15,635,353	22,745		1,383,266	2,012	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 492,623	$		$ 43,583	25

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	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).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2015 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.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Mill Creek 3 COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047258

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-24-252-001	Residential - Tax exempt	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,815 B. General Construction Type: Exterior Brick/Cedar Frame Wood/Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Marklund Hyde Center Day Training 43,000 Square Feet 112 Person Capacity
Marklund Haverkampf Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity
Marklund VanDerMolen Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity
Marklund Tommy Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity
Marklund Sayers Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity
Marklund Richard Home 16-Bed Facility 8,815 Square Feet 16 Person Capacity

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	116,479	2004	$ 550,105	1
2					2
3	TOTALS	116,479		$ 550,105	3

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2006	2006	$ 1,404,275	$ 70,214	20	$ 70,214	$	$ 667,031	4
5			2006	2006	159,630	15,963	10	15,963		151,649	5
6			2006	2006	42,499	4,250	10	4,250		40,374	6
7											7
8											8
	Improvement Type**										
9	LI Repairs to asphalt path			2006	1,410		5			1,410	9
10	BI Corian Countertop Replacement			2008	1,130		5			1,130	10
11	BI Lightning Protection System			2008	3,100		5			3,100	11
12	LI Hot Rubber Crackfill Repair			2008	427		2			427	12
13	LI Sealcoating Driveway/Sidewalks			2008	1,525		2			1,525	13
14	LI Trash Enclosure Fence Repair			2009	447		5			447	14
15	LI Installation of 2 Bollard Lights			2009	637		5			637	15
16	BI Corian Repair - Nurses Desk			2009	500		5			500	16
17	LI Replacement of dumpster gate			2010	166	17	5	17		166	17
18	LI Asphalt Repairs-North Approach to NE Parking Lot			2011	1,217	243	5	243		1,096	18
19	LI Replacement-Asphalt Sidewalks w/Concrete			2011	4,501	450	10	450		2,025	19
20	LI Replace Asphalt Sidewalks w/Concrete			2011	4,667	467	10	467		2,100	20
21	BI Replacement of Door Frame			2012	1,639	328	5	328		1,147	21
22	LI Refurbishing of Exterior Signs			2012	1,664	333	5	333		1,165	22
23	LI Asphalt Repairs-North Approach to NE Parking Lot			2012	163	33	5	33		114	23
24	BI Hardi-Trim Replacement-Patio Columns			2013	1,075	215	5	215		538	24
25	LI Concrete Replacement - Patio			2013	2,344	469	5	469		1,172	25
26	LI Wheelchair Glider w/ Concrete Pad			2013	1,562	312	5	312		781	26
27	LI Concrete Replacement of Asphalt sidewalk			2014	2,833	283	10	283		425	27
28	LI Replace Asphalt with Concrete			2015	4,017	201	10	201		201	28
29	LI Dreher Home Exterior Sign			2015	1,850	185	5	185		185	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,643,277	$ 93,962		$ 93,962	$	$ 879,343	70

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

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

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	$ 9,210,989	$ 15,543	$ 15,543	$		$ 55,529	71
72	Current Year Purchases	6,692	1,009	1,009			1,009	72
73	Fully Depreciated Assets	141,575					141,575	73
74								74
75	TOTALS	$ 9,359,255	$ 16,552	$ 16,552	$		$ 198,113	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 (1/2)	2008 Ford El Dorado Bus	2008	$ 24,925	$	$	$	5	$ 24,925	76
77	Snow Plow Truck	2012 Ford F-350 (1/6)	2012	7,517	1,503	1,503		5	5,227	77
78	Maintenance	2013 Ford F-250 Truck (1/6)	2013	4,586	917	917		5	2,263	78
79	Patient Transport	2014 Ford Ambulette (1/6)	2015	5,978	598	598		5	598	79
80	TOTALS			$ 43,006	$ 3,018	$ 3,018	$		$ 33,012	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)	$ 11,595,643	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 113,532	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 113,532	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,110,468	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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 3,494 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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15 (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	$ 708,174	$ 708,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 234,000)	2,764,757	2,764,757	3
4	Supply Inventory (priced at)	87,943	87,943	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	270,947	270,947	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): client related accounts	692,889	692,889	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,524,710	$ 4,524,710	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,545,264	6,545,264	13
14	Buildings, at Historical Cost	23,376,619	23,376,619	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,458,710	5,458,710	16
17	Accumulated Depreciation (book methods)	(20,106,391)	(20,106,391)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	9,863,824	9,863,824	21
22	Other Long-Term Assets (specify):	6,059,674	6,059,674	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 31,197,700	$ 31,197,700	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,722,410	$ 35,722,410	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 513,048	$ 513,048	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,516	254,516	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,054	20,054	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	compensation & related payables	266,981	266,981	36
37	misc. other	1,704,934	1,704,934	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,759,533	$ 2,759,533	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)**	$ 2,759,533	$ 2,759,533	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 32,962,877	$ 32,962,877	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,722,410	$ 35,722,410	48

*(See instructions.)

Facility Name & ID Number Marklund Mill Creek 3 # 0047258 Report Period Beginning: 07/01/14 Ending: 06/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 32,954,931	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,954,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,423)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,569,088	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) **Remaining Consolidated Income**	(1,487,667)	15
16	Other (describe) **loss on disposal of building & equipment**	(21,109)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (295,111)	17
	B. Transfers (Itemize):		
18	**Transfers out of Restricted Funds into Operations- exp.**	303,057	18
19	**Transfers out of Restricted Funds into Operations-capital**	453,387	19
20	**Transfers into Operations from Restricted Funds**	(453,387)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 303,057	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 32,962,877	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,294,235	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,294,235	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 1,294,235	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	191,019	31
32	Health Care	911,567	32
33	General Administration	335,778	33
	B. Capital Expense		
34	Ownership	133,653	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	77,641	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,649,658	40
41	**Income before Income Taxes (line 30 minus line 40)****	(355,423)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (355,423)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,201,534	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	92,701	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,294,235	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	277	291	$ 13,040	$ 44.81	1
2	Assistant Director of Nursing	652	686	20,976	30.58	2
3	Registered Nurses	6,422	6,760	204,526	30.26	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	26,044	27,414	404,362	14.75	5
6	CNA Trainees					6
7	Licensed Therapist	2,035	2,142	81,111	37.87	7
8	Rehab/Therapy Aides	277	291	4,199	14.43	8
9	Activity Director	336	354	8,133	22.97	9
10	Activity Assistants	2,035	2,142	29,308	13.68	10
11	Social Service Workers	257	270	4,329	16.03	11
12	Dietician					12
13	Food Service Supervisor	672	707	19,830	28.05	13
14	Head Cook	316	333	5,375	16.14	14
15	Cook Helpers/Assistants	316	333	3,661	10.99	15
16	Dishwashers	316	333	3,771	11.32	16
17	Maintenance Workers	632	666	19,522	29.31	17
18	Housekeepers	1,324	1,394	15,469	11.10	18
19	Laundry	1,324	1,394	13,253	9.51	19
20	Administrator	316	333	16,001	48.05	20
21	Assistant Administrator	336	354	11,191	31.61	21
22	Other Administrative	316	333	20,441	61.38	22
23	Office Manager					23
24	Clerical	435	458	8,045	17.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	34,944	16.80	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	277	291	3,899	13.40	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	47,385	49,879	$ 951,813 *	$ 19.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	47	$ 2,366	1	35
36	Medical Director	monthly	4,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	782	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	408	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	9	723	15	46
47	Vision	15	338	15	47
48	Dental	34	850	15	48
49	TOTAL (lines 35 - 48)	111	$ 9,467		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	240	$ 10,149	10	50
51	Licensed Practical Nurses	170	6,095		51
52	Certified Nurse Assistants/Aides	716	15,350	10	52
53	TOTAL (lines 50 - 52)	1,126	$ 31,594		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachelle Jewison	Administrator		$ 16,001
Antonio Quinones	Asst. Admin.		11,191
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,192

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	audit fees	$ 4,247
Robin R Kelleher	legal fees	1,062
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 5,309

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,429
Unemployment Compensation Insurance	7,218
FICA Taxes	72,814
Employee Health Insurance	75,149
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	15,877
Dental	6,949
Life Insurance	1,553
Long Term Disability	122
TOTAL (agree to Schedule V, line 22, col.8)	$ 204,111

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,401
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues/subscriptions	1,771
IHCA Dues	960
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,132

G. Schedule of Travel and Seminar**

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

**See instructions.

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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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Healthcare Association , $960**

(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. $ **14,204** 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. $ **77,641**
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? **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.

Type	Manufacturer	Model	Qty
Copier	Minolta	BizHub 224E	1