

Facility Name & ID Number Marklund Richard Home

0047266 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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	5,856	6
7	16	TOTALS	16	5,856	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	5,722			5,722	13
14	TOTALS	5,722			5,722	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.71%

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

20 (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 06/16/06

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: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	19,450	1,250	2,979	23,678		23,678		23,678		1
2	Food Purchase		42,565		42,565		42,565		42,565		2
3	Housekeeping	15,469	5,416	1,757	22,641		22,641		22,641		3
4	Laundry	13,588	2,898		16,486		16,486		16,486		4
5	Heat and Other Utilities			28,575	28,575		28,575		28,575		5
6	Maintenance	19,522	6,193	16,177	41,892		41,892		41,892		6
7	Other (specify):* Disposal Services			1,734	1,734		1,734		1,734		7
8	TOTAL General Services	68,028	58,322	51,221	177,571		177,571		177,571		8
	B. Health Care and Programs										
9	Medical Director			4,000	4,000		4,000		4,000		9
10	Nursing and Medical Records	631,881	40,856	21,160	693,898		693,898		693,898		10
10a	Therapy	77,341	215	100	77,656		77,656		77,656		10a
11	Activities	35,447	5,136		40,583		40,583		40,583		11
12	Social Services	4,329			4,329		4,329		4,329		12
13	CNA Training										13
14	Program Transportation	6,427		14,865	21,292		21,292		21,292		14
15	Other (specify):* Vision, Dental, Pharmacy & Pysch consultants			2,811	2,811		2,811		2,811		15
16	TOTAL Health Care and Programs	755,425	46,208	42,937	844,569		844,569		844,569		16
	C. General Administration										
17	Administrative	26,667			26,667		26,667		26,667		17
18	Directors Fees										18
19	Professional Services			6,033	6,033		6,033		6,033		19
20	Dues, Fees, Subscriptions & Promotions			9,124	9,124		9,124	(2,924)	6,200		20
21	Clerical & General Office Expenses	16,594	24,058	5,446	46,098	(4,183)	41,915		41,915		21
22	Employee Benefits & Payroll Taxes			194,364	194,364		194,364		194,364		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,344	2,344		2,344	(2,344)	(0)		24
25	Other Admin. Staff Transportation			2,302	2,302		2,302	(2,302)	0		25
26	Insurance-Prop.Liab.Malpractice			23,847	23,847		23,847		23,847		26
27	Other (specify):* fund-raising/promotional			1,667	1,667		1,667	(1,667)	(0)		27
28	TOTAL General Administration	43,260	24,058	245,127	312,446	(4,183)	308,263	(9,237)	299,026		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	866,713	128,587	339,285	1,334,585	(4,183)	1,330,402	(9,237)	1,321,165		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			111,216	111,216		111,216	(5,871)	105,345			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			761	761		761	(761)	(0)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			8,718	8,718		8,718	(8,718)	0			34
35	Rent-Equipment & Vehicles					4,183	4,183		4,183			35
36	Other (specify):*											36
37	TOTAL Ownership			120,695	120,695	4,183	124,879	(15,350)	109,529			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			77,266	77,266		77,266		77,266			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			77,266	77,266		77,266		77,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	866,713	128,587	537,246	1,532,547		1,532,547	(24,587)	1,507,960			45

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

VI. ADJUSTMENT DETAIL

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

		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	(761)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,924)	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	(19,235)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,587)		\$	30

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))	\$ (24,587)		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

BHF USE ONLY							
48		49		50		51	52

Marklund Richard Home

ID# 0047266

Report Period Beginning: 07/01/15

Ending: 06/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Seminars	\$ (2,344)	24	1
2	Travel & Sustenance	(2,302)	25	2
3	Depreciation	(5,871)	30	3
4	Rent	(8,718)	34	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,235)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Richard Home# 0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	(2,924)	0	0	0	0	0	0	0	0	0	0	(2,924)	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	(2,344)	0	0	0	0	0	0	0	0	0	0	(2,344)	24
25	Other Admin. Staff Transportation	(2,302)	0	0	0	0	0	0	0	0	0	0	(2,302)	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	(9,237)	0	0	0	0	0	0	0	0	0	0	(9,237)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,237)	0	0	0	0	0	0	0	0	0	0	(9,237)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(5,871)	0	0	0	0	0	0	0	0	0	0	(5,871) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(761)	0	0	0	0	0	0	0	0	0	0	(761) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	(8,718)	0	0	0	0	0	0	0	0	0	0	(8,718) 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	(15,350)	0	0	0	0	0	0	0	0	0	0	(15,350) 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)	(24,587)	0	0	0	0	0	0	0	0	0	0	(24,587) 45

Facility Name & ID Number

Marklund Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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.

Facility Name & ID Number

Marklund Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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 Richard Home

0047266

Report Period Beginning:

07/01/15

Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	15,991,092	15,991,092	\$ 8	\$ 1,366,796	\$ 1	1
2	2	Food	Direct Cost Budget	15,991,092	15,991,092	1,033	1,366,796	88	2
3	3	Housekeeping	Direct Cost Budget	15,991,092	15,991,092	5,856	1,366,796	501	3
4	5	Utilities	Direct Cost Budget	15,991,092	15,991,092	52,741	1,366,796	4,508	4
5	6	Maintenance	Direct Cost Budget	15,991,092	15,991,092	16,445	1,366,796	1,406	5
6	7	Disposal	Direct Cost Budget	15,991,092	15,991,092	3,476	1,366,796	297	6
7	13	BNATP	Direct Cost Budget	15,991,092	15,991,092	0	1,366,796	0	7
8	14	Transportation	Direct Cost Budget	15,991,092	15,991,092	5,672	1,366,796	485	8
9	19	Professional Services	Direct Cost Budget	15,991,092	15,991,092	58,590	1,366,796	5,008	9
10	20	Fees,Subscription	Direct Cost Budget	15,991,092	15,991,092	60,531	1,366,796	5,174	10
11	21	Clerical/Office	Direct Cost Budget	15,991,092	15,991,092	202,404	1,366,796	17,300	11
12	22	Benefits	Direct Cost Budget	15,991,092	15,991,092	66,810	1,366,796	5,710	12
13	24	Travel & Seminar	Direct Cost Budget	15,991,092	15,991,092	11,757	1,366,796	1,005	13
14	25	Staff Transportation	Direct Cost Budget	15,991,092	15,991,092	7,592	1,366,796	649	14
15	26	Insurance	Direct Cost Budget	15,991,092	15,991,092	20,945	1,366,796	1,790	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 513,861	\$	\$ 43,922	25

Facility Name & ID Number

Marklund Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Richard Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047266

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 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Marklund Richard Home

0047266 Report Period Beginning:

07/01/15 Ending:

06/30/16

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 Centrer Day Training 43,000 sf 112 preson capacity
Marklund Haverkamp Home 16 bed facility 8815 sf 16 person capacity
Marklund Van Der Molen Home 16 bed facility 8315sf 16 person capcaity
Marklund Tommy Home 16 bed facility 8315 sf 16 person capacity
Marklund Sayers Home 16 bed facility 8315 sf 16 person capacity
Marklund Dreher Home 16 bed facility 8315 sf 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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Patent Care, 2004, \$329,981. Row 2: (blank), (blank), (blank). Row 3: TOTALS, \$329,981.

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	2006	2006	\$ 1,404,275	\$ 70,214	20	\$ 70,214	\$	\$ 737,244
5		2006	2006	106,795	5,340	10	5,340		106,795
6		2006	2006	42,499	2,125	10	2,125		42,499
7									
8									
Improvement Type**									
9	LI singel faced sandblasted cedar signage		2007	1,450		5			1,450
10	BI lightning protection system		2008	3,100		5			3,100
11	LI hot rubber crackfill repair		2008	427		2			427
12	LI sealcoating driveway/sidewalks		2008	1,525		2			1,525
13	LI trash enclosure ference repair		2009	447		5			447
14	LI installation of 2 bollard lights		2009	637		5			637
15	LI replacement of dumpster gate		2010	166		5			166
16	LI asphalt repiars - north approach to NE parking lot		2011	1,217	122	5	122		1,217
17	LI replacement - asphalt sidewalk w/concrete		2011	4,501	450	10	450		2,475
18	LI replace asphalt sidewalk w/ caoncrete		2011	4,667	467	10	467		2,567
19	LI refurbishing of exterior signs		2012	1,664	333	5	333		1,498
20	LI ashpalt repairs (split w/ homes)		2012	163	33	5	33		146
21	BI hardi trim replacement - patio		2013	1,075	215	5	215		753
22	LI concrete replacement - patio		2013	2,344	469	5	469		1,640
23	LI wheelchair glider w/concrete pad		2013	1,562	312	5	312		1,093
24	LI concrete replacement of asphalt sidewalk		2014	2,833	283	10	283		708
25	LI phase III replace asphalt w/ concrete		2015	4,017	402	10	402		603
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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)	\$	\$		\$	\$	\$	70
			1,585,362		80,763		80,763	906,990

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

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	\$ 81,058	\$ 15,728	\$ 15,728	\$		\$ 52,919	71
72	Current Year Purchases	21,108	2,305	2,305			2,305	72
73	Fully Depreciated Assets	168,029					167,931	73
74								74
75	TOTALS	\$ 270,195	\$ 18,033	\$ 18,033	\$		\$ 223,155	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	2016 Ford Starcraft Bus (1/2)	2016	\$ 29,330	\$ 2,933	\$ 2,933	\$	5	\$ 2,933	76
77	Snow Plow Truck	2012 Ford F-350 (1/6)	2012	7,517	1,503	1,503		5	6,765	77
78	Maintenance	2013 Ford F-250 Truck (1/6)	2013	4,586	917	917		5	3,210	78
79	Patient Transport	2014 Ford Ambulette (1/6)	2015	5,978	1,196	1,196		5	1,793	79
80	TOTALS			\$ 47,411	\$ 6,549	\$ 6,549	\$		\$ 14,701	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)	\$ 2,232,949	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,345	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,345	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)	\$ 1,144,846	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 Richard Home

0047266

Report Period Beginning: 07/01/15

Ending: 06/30/16

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 4,183 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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? <input type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	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 prescripts							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 Richard Home**

0047266

Report Period Beginning: **07/01/15**

Ending:

06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 842,189	\$ 842,189	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>246,500</u>)	2,639,956	2,639,956	3
4	Supply Inventory (priced at _____)	81,185	81,185	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	180,974	180,974	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	667,714	667,714	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,412,018	\$ 4,412,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,865,917	6,865,917	13
14	Buildings, at Historical Cost	25,506,038	25,506,038	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,270,044	6,270,044	16
17	Accumulated Depreciation (book methods)	(21,543,200)	(21,543,200)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,916,012	6,916,012	21
22	Other Long-Term Assets (specify): _____	5,393,729	5,393,729	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,408,540	\$ 29,408,540	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,820,558	\$ 33,820,558	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 262,582	\$ 262,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,358	312,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,052	24,052	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>	(184,258)	(184,258)	36
37	<u>misc. other</u>	1,480,580	1,480,580	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,895,314	\$ 1,895,314	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)	\$ 1,895,314	\$ 1,895,314	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,925,244	\$ 31,925,244	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,820,558	\$ 33,820,558	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 32,962,877	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,962,877	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(140,783)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	839,788	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	(2,673,616)	15
16	Other (describe) loss on disposal of building & equipment	8,192	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,966,419)	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- exp.	928,786	18
19	Transfers out of Restricted Funds into Operations-capital	290,306	19
20	Transfers into Operations from Restricted Funds	(290,306)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 928,786	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,925,244	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning: 07/01/15

Ending: 06/30/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,271,068	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,271,068	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)	\$ 1,271,068	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	177,571	31
32	Health Care	844,569	32
33	General Administration	312,446	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	77,266	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,411,851	40
41	Income before Income Taxes (line 30 minus line 40)**	(140,783)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (140,783)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,141,036	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	130,032	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,271,068	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 Richard Home

0047266

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	277	291	\$ 10,506	\$ 36.08	1
2	Assistant Director of Nursing	988	1,040	31,782	30.56	2
3	Registered Nurses	6,896	7,259	181,480	25.00	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	24,660	25,958	379,252	14.61	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	2,035	2,142	73,142	34.14	7
8	Rehab/Therapy Aides	277	291	4,199	14.42	8
9	Activity Director	316	333	6,992	21.01	9
10	Activity Assistants	1,976	2,080	28,454	13.68	10
11	Social Service Workers	257	270	4,329	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	336	354	7,822	22.12	13
14	Head Cook	316	333	5,375	16.15	14
15	Cook Helpers/Assistants	316	333	3,258	9.79	15
16	Dishwashers	316	333	2,995	9.00	16
17	Maintenance Workers	632	666	19,522	29.33	17
18	Housekeepers	1,324	1,394	15,469	11.10	18
19	Laundry	1,324	1,394	13,588	9.75	19
20	Administrator	316	333	15,475	46.50	20
21	Assistant Administrator	336	354	11,191	31.65	21
22	Other Administrative	165	173	9,802	56.57	22
23	Office Manager	0	0	0		23
24	Clerical	415	437	6,792	15.55	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)	1,482	1,560	25,074	16.07	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	277	291	3,786	13.00	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)	45,731	48,138	\$ 866,713 *	\$ 18.00	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	44	\$ 2,217	1	35
36	Medical Director	monthly	4,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,004	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	varies	100	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	5	425	15	46
47	<u>Vision</u>	visit	383	15	47
48	<u>Dental</u>	vist	1,000	15	48
49	TOTAL (lines 35 - 48)	49	\$ 9,128		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	149	\$ 8,173	10	50
51	Licensed Practical Nurses	77	3,385	10	51
52	Certified Nurse Assistants/Aides	121	9,603	10	52
53	TOTAL (lines 50 - 52)	347	\$ 21,160		53

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 , \$912
- (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. \$ 13,091 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. \$ 77,266
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 benefit 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. _____
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>	<u>Location</u>
Copier	Minolta	BizHub 224E	1	MRH