

		FOR BHF USE				

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

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

<p><b>I. IDPH License ID Number:</b> <u>0045575</u></p> <p><b>Facility Name:</b> <u>Marklund Sayers Home</u></p> <p><b>Address:</b> <u>1 South 383 Wyatt Dr</u> <u>Geneva</u> <u>60134</u>        Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>(630) 593-5496</u> <b>Fax #</b> <u>(630) 397-5038</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>08/25/03</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/15</u> to <u>06/30/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Gilbert W. Fonger</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>CEO/President</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>( )</u> Fax # <u>( )</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Gilbert W. Fonger</u>			(Title) <u>CEO/President</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # <u>( )</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) <u>( )</u> Fax # <u>( )</u>																																									
<p>In the event there are further questions about this report, please contact:  <b>Name:</b> <u>Lynn Melvin</u> <b>Telephone Number:</b> <u>(630)593-5485</u>  <b>Email Address:</b> _____</p>	<p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>																																									

Facility Name & ID Number Marklund Sayers Home

# 0045575 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	5,471	366		5,837	13
14	TOTALS	5,471	366		5,837	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 99.68%

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

7 (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 08/25/03

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

YES  Date \_\_\_\_\_ NO

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

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

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Marklund Sayers Home # 0045575 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
	<b>A. General Services</b>										
1	Dietary	32,853	1,295	2,914	37,062		37,062	37,062			1
2	Food Purchase		42,658		42,658		42,658	42,658			2
3	Housekeeping	15,469	5,377	1,757	22,603		22,603	22,603			3
4	Laundry	13,253	2,898		16,152		16,152	16,152			4
5	Heat and Other Utilities			26,723	26,723		26,723	26,723			5
6	Maintenance	19,522	4,787	12,333	36,642		36,642	36,642			6
7	Other (specify):* <b>Disposal Services</b>			1,734	1,734		1,734	1,734			7
8	<b>TOTAL General Services</b>	<b>81,097</b>	<b>57,015</b>	<b>45,461</b>	<b>183,573</b>		<b>183,573</b>	<b>183,573</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,000	4,000		4,000	4,000			9
10	Nursing and Medical Records	694,972	34,437	34,941	764,351		764,351	764,351			10
10a	Therapy	85,310		288	85,598		85,598	85,598			10a
11	Activities	37,441	5,527		42,967		42,967	42,967			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):* <b>Vision, Dental, Pharmacy &amp; Pysch consultants</b>			3,522	3,522		3,522	3,522			15
16	<b>TOTAL Health Care and Programs</b>	<b>828,480</b>	<b>39,964</b>	<b>57,616</b>	<b>926,059</b>		<b>926,059</b>	<b>926,059</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	27,192			27,192		27,192	27,192			17
18	Directors Fees										18
19	Professional Services			6,033	6,033		6,033	6,033			19
20	Dues, Fees, Subscriptions & Promotions			9,069	9,069		9,069	(2,917)	6,152		20
21	Clerical & General Office Expenses	28,485	24,054	5,391	57,930	(4,373)	53,557	53,557			21
22	Employee Benefits & Payroll Taxes			216,463	216,463		216,463	216,463			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,430	2,430		2,430	(2,430)	(0)		24
25	Other Admin. Staff Transportation			3,888	3,888		3,888	(3,888)	(0)		25
26	Insurance-Prop.Liab.Malpractice			23,847	23,847		23,847	23,847			26
27	Other (specify):* <b>fund-raising/promotional</b>			1,667	1,667		1,667	(1,667)	(0)		27
28	<b>TOTAL General Administration</b>	<b>55,678</b>	<b>24,054</b>	<b>268,787</b>	<b>348,519</b>	<b>(4,373)</b>	<b>344,146</b>	<b>(10,902)</b>	<b>333,244</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>965,255</b>	<b>121,033</b>	<b>371,864</b>	<b>1,458,152</b>	<b>(4,373)</b>	<b>1,453,779</b>	<b>(10,902)</b>	<b>1,442,877</b>		<b>29</b>

\*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			103,085	103,085		103,085	(8,701)	94,384		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					4,373	4,373		4,373		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			112,564	112,564	4,373	116,937	(18,180)	98,757		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			80,258	80,258		80,258		80,258		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			80,258	80,258		80,258		80,258		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	965,255	121,033	564,686	1,650,974		1,650,974	(29,082)	1,621,892		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	(2,917)	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	(23,737)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (29,082)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (29,082)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Marklund Sayers Home

ID# 0045575

Report Period Beginning: 07/01/15

Ending: 06/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Seminars	\$ (2,430)	24	1
2	Travel & Sustenance	(3,888)	25	2
3	Depreciation	(8,701)	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
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(23,737)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Sayers Home

# 0045575

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	(2,917)	0	0	0	0	0	0	0	0	0	0	(2,917)	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	(2,430)	0	0	0	0	0	0	0	0	0	0	(2,430)	24
25	Other Admin. Staff Transportation	(3,888)	0	0	0	0	0	0	0	0	0	0	(3,888)	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	<b>TOTAL General Administration</b>	(10,902)	0	0	0	0	0	0	0	0	0	0	(10,902)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(10,902)	0	0	0	0	0	0	0	0	0	0	(10,902)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Sayers Home

# 0045575

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	(8,701)	0	0	0	0	0	0	0	0	0	0	(8,701)	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	<b>TOTAL Ownership</b>	<b>(18,180)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(18,180)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(29,082)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,082)</b>	<b>45</b>



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 Sayers Home

# 0045575

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 Sayers Home # 0045575 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 Sayers Home

# 0045575

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	15991092	15991092	\$ 8	\$ 1,366,796	\$ 1	1
2	2	Food	Direct Cost Budget	15991092	15991092	1,033	1,366,796	88	2
3	3	Housekeeping	Direct Cost Budget	15991092	15991092	5,856	1,366,796	501	3
4	5	Utilities	Direct Cost Budget	15991092	15991092	52,741	1,366,796	4,508	4
5	6	Maintenance	Direct Cost Budget	15991092	15991092	16,445	1,366,796	1,406	5
6	7	Disposal	Direct Cost Budget	15991092	15991092	3,476	1,366,796	297	6
7	13	BNATP	Direct Cost Budget	15991092	15991092	0	1,366,796	0	7
8	14	Transportation	Direct Cost Budget	15991092	15991092	5,672	1,366,796	485	8
9	19	Professional Services	Direct Cost Budget	15991092	15991092	58,590	1,366,796	5,008	9
10	20	Fees,Subscription	Direct Cost Budget	15991092	15991092	60,531	1,366,796	5,174	10
11	21	Clerical/Office	Direct Cost Budget	15991092	15991092	202,404	1,366,796	17,300	11
12	22	Benefits	Direct Cost Budget	15991092	15991092	66,810	1,366,796	5,710	12
13	24	Travel & Seminar	Direct Cost Budget	15991092	15991092	11,757	1,366,796	1,005	13
14	25	Staff Transportation	Direct Cost Budget	15991092	15991092	7,592	1,366,796	649	14
15	26	Insurance	Direct Cost Budget	15991092	15991092	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 Sayers Home

# 0045575

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	N/A						\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	N/A											6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9						
<b>B. Non-Facility Related*</b>																		
10	N/A											10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**  
**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.		\$	<b>N/A</b>	<b>1</b>
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.)		\$		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>#VALUE!</b>	<b>3</b>
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>#VALUE!</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	_____	<b>8</b>	
	2012	_____	<b>9</b>	
	2013	_____	<b>10</b>	
	2014	_____	<b>11</b>	
	2015	_____	<b>12</b>	
<b>FOR BHF USE ONLY</b>				
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2015	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Marklund Sayers Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045575

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

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. <u>11-24-191-002</u>	<u>Residential - Tax exempt</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ _____	\$ _____

**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 Sayers Home

# 0045575 Report Period Beginning:

07/01/15 Ending:

06/30/16

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 8,315 B. General Construction Type: Exterior brick/cedar Frame wood/steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Marklund Hyde Center Day Training 43,000 sf 112 person capacity

Marklund Haverkamp Home 16 bed facility 8315 sf 16 person capacity

Marklund Van Der Molen Home 16 bed facility 8315 sf 16 person capacity

Marklund Tommy Home 16 bed facility 8315 sf 16 person capacity

Marklund Dreher Home 16 bed facility 8815 sf 16 person capacity

Marklund Richard Home 16 bed facility 8815 sf 16 person capacity

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Patirnt Care	67,518	1999	\$ 318,871	1
2					2
3	TOTALS	67,518		\$ 318,871	3



Facility Name & ID Number Marklund Sayers Home# 0045575

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	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264		\$ 765,796	4
5			2003	2003	76,537		10			76,537	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		BI electrical upgrade	2003		3,199		5			3,199	9
10		BI Gutter Installation	2004		383		5			383	10
11		BI emergency battery lights - generator	2005		333		10			333	11
12		LI sealcoating of driveway and paths	2005		1,712		2			1,712	12
13		LI grading and seeding of land parcel	2005		301		5			301	13
14		LI bollard lighting	2005		1,300		5			1,300	14
15		LI concrete slabs by dumpsters	2006		1,950		5			1,950	15
16		LI cutom exterior signage	2006		1,227		5			1,227	16
17		BI painting of interior	2007		4,683		5			4,683	17
18		BI lightning proctection system	2008		3,100		5			3,100	18
19		BI tile instsallation under kitchen cabinets	2008		771		5			771	19
20		LI hot rubbrt crackfill repair	2008		427		2			427	20
21		LI sealcoating driveay/sidealks	2008		1,525		2			1,525	21
22		LI installaton oif 2 bollard lights	2009		637		5			637	22
23		BI epoxy bathroom floors	2009		5,858		5			5,858	23
24		BI oak plywood shelving	2009		1,045		5			1,045	24
25		LI replacement of dumpdter gate	2010		166		5			166	25
26		BI door/threshold replacemenmt	2010		3,623		5			3,623	26
27		BI replacement of baseboard trim a& wall carpeting	2011		25,000	2,500	5	2,500		25,000	27
28		LI asphalt repairs noprth approach to NE parking lot	2011		1,217	122	5	122		1,217	28
29		LI replacement asphalt sidewalk w/concrete	2011		4,501	450	10	450		2,475	29
30		LI replacement asphalt sidewalk w/concrete	2011		4,667	467	10	467		2,567	30
31		BI gutter extension over patio	2012		423	85	5	85		380	31
32		LI refurbishing of exterior signs	2012		1,664	333	5	333		1,498	32
33		LI asphalt repairs (split w/homes)	2012		163	33	5	33		146	33
34		BI comfort pro condenser	2013		3,300	660	5	660		2,310	34
35		LI wheelchair glider w/concrete pad	2013		1,562	312	5	312		1,093	35
36		LI concrete replacement of asphalt sidewalk	2014		2,833	283	10	283		708	36

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

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**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	2015	\$ 46,500	\$ 9,300	5	\$ 9,300	\$	\$ 13,950	37
38	2015	4,017	402	10	402		603	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)		\$ 1,429,896	\$ 76,209		\$ 76,209	\$ 926,520	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 66,720	\$ 13,470	\$ 13,470	\$		\$ 43,754	71
72	Current Year Purchases	9,069	1,088	1,088			1,088	72
73	Fully Depreciated Assets	120,357					120,357	73
74								74
75	TOTALS	\$ 196,146	\$ 14,558	\$ 14,558	\$		\$ 165,199	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	2008 Ford El Dorado (1/2)	2008	\$ 24,925	\$	\$	\$	5	\$ 24,925	76
77	Snow Plow Truck	2012FORD f-350 (1/6)	2012	7,517	1,503	1,503		5	6,765	77
78	Patient Transport	2014 Ford Ambulette (1/6)	2015	5,978	1,196	1,196		5	1,794	78
79	Maintenance	2013 Ford F-250 Truck (1/6)	2013	4,586	917	917		5	3,210	79
80	TOTALS			\$ 43,006	\$ 3,616	\$ 3,616	\$		\$ 36,694	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,987,918	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,384	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,384	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)	\$ 1,128,413	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 Sayers Home

# 0045575

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	<b>TOTAL</b>				\$			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: \$ 4,373

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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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	<b>TOTAL</b>			\$		\$	\$		\$	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 &amp; ID Number Marklund Sayers Home

# 0045575

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*	
	<b>A. Current Assets</b>			
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 246,500 )	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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,412,018	\$ 4,412,018	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 29,408,540	\$ 29,408,540	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 33,820,558	\$ 33,820,558	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<u>compensation &amp; related payables</u>	(184,258)	(184,258)	36
37	<u>misc. other</u>	1,480,580	1,480,580	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,895,314	\$ 1,895,314	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,895,314	\$ 1,895,314	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 31,925,244	\$ 31,925,244	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 33,820,558	\$ 33,820,558	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>32,962,877</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>32,962,877</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(192,458)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	839,788	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Remaining Consolidated Income</b>	(2,621,941)	<b>15</b>
<b>16</b>	Other (describe) <b>loss on disposal of building &amp; equipment</b>	8,192	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (1,966,419)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfers out of Restricted Funds into Operations- exp.</b>	928,786	<b>18</b>
<b>19</b>	<b>Transfers out of Restricted Funds into Operations-capital</b>	290,306	<b>19</b>
<b>20</b>	<b>Transfers into Operations from Restricted Funds</b>	(290,306)	<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 928,786	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 31,925,244	<b>24</b> *

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



Facility Name &amp; ID Number Marklund Sayers Home

# 0045575

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,345,952	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,345,952	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,345,952	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	183,573	31
32	Health Care	926,059	32
33	General Administration	348,519	33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	80,258	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,538,410	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(192,458)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (192,458)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,154,886	44
45	Private Pay - Net Inpatient Revenue	96,803	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SSA</u>	94,263	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,345,952	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 Sayers Home

# 0045575

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	\$ 13,040	\$ 44.78	1
2	Assistant Director of Nursing	652	686	20,976	30.56	2
3	Registered Nurses	6,343	6,677	218,364	32.70	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	26,004	27,373	403,749	14.75	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	2,035	2,142	81,111	37.86	7
8	Rehab/Therapy Aides	277	291	4,199	14.42	8
9	Activity Director	336	354	8,133	23.00	9
10	Activity Assistants	2,035	2,142	29,308	13.68	10
11	Social Service Workers	257	270	4,329	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	652	686	19,247	28.04	13
14	Head Cook	336	354	5,711	16.15	14
15	Cook Helpers/Assistants	336	354	3,890	11.00	15
16	Dishwashers	336	354	4,006	11.33	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	13,253	9.51	19
20	Administrator	316	333	16,001	48.08	20
21	Assistant Administrator	336	354	11,191	31.65	21
22	Other Administrative	316	333	20,441	61.42	22
23	Office Manager	0	0	0		23
24	Clerical	435	458	8,045	17.58	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,976	2,080	34,944	16.80	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	277	291	3,899	13.39	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	47,305	49,795	\$ 965,255 *	\$ 19.38	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	393	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	12	978	15	46
47	<u>Vision</u>	visit	338	15	47
48	<u>Dental</u>	vist	1,203	15	48
49	TOTAL (lines 35 - 48)	56	\$ 10,131		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	338	\$ 17,331	10	50
51	Licensed Practical Nurses	165	6,771	10	51
52	Certified Nurse Assistants/Aides	206	10,839	10	52
53	TOTAL (lines 50 - 52)	709	\$ 34,941		53

<b>XIX. SUPPORT SCHEDULES</b>			
<b>A. Administrative Salaries</b>			
Name	Function	Ownership %	Amount
Rachelle Jewison	Administrator		\$ 18,859
Antonio Quinones	Asst. Admin.		8,333
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,192
<b>B. Administrative - Other</b>			
Description	Amount		
	\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
<b>C. Professional Services</b>			
Vendor/Payee	Type	Amount	
KPMG	audit fees	\$ 5,007	
Robin R Kelleher	legal fees	1,026	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,033
<b>D. Employee Benefits and Payroll Taxes</b>			
Description	Amount		
Workers' Compensation Insurance	\$ 27,435		
Unemployment Compensation Insurance	7,522		
FICA Taxes	73,842		
Employee Health Insurance	81,960		
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension	16,755		
Dental	7,213		
Life Insurance	1,656		
Long Term Disability	79		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 216,463
<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			
Description	Line #	Amount	
		\$	
TOTAL			\$
<b>F. Dues, Fees, Subscriptions and Promotions</b>			
Description	Amount		
IDPH License Fee	\$		
Advertising: Employee Recruitment	4,768		
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Dues/subscriptions	472		
IHCA Dues	912		
Less: Public Relations Expense			( )
Non-allowable advertising			( )
Yellow page advertising			( )
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 6,152
<b>G. Schedule of Travel and Seminar**</b>			
Description	Amount		
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense			
Entertainment Expense	( )		
TOTAL (agree to Sch. V, line 24, col. 8)			\$

\* Attach copy of IMRF notifications \*\*See instructions.

Facility Name & ID Number Marklund Sayers Home# 0045575Report Period Beginning: 07/01/15Ending: 06/30/16**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. \$ 12,371 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. \$ 80,258  
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