

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

<p>I. IDPH License ID Number: <u>0047258</u></p> <p>Facility Name: <u>Marklund Dreher Home</u></p> <p>Address: <u>1S381 Wyatt Drive</u> <u>Geneva</u> <u>60134</u> Number City Zip Code</p> <p>County: <u>Kane</u></p> <p>Telephone Number: <u>(630) 593-5168</u> Fax # <u>(630) 397-5165</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/09/06</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> Limited Liability Co. _____</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> <p>In the event there are further questions about this report, please contact: Name: <u>Lynn Melvin</u> Telephone Number: <u>(630) 593-5485</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. _____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/17</u> to <u>06/30/18</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> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Type or Print Name) <u>Gilbert W. Fonger</u></td> </tr> <tr> <td>(Title) <u>CEO/President</u></td> </tr> <tr> <td rowspan="5"></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Gilbert W. Fonger</u>	(Title) <u>CEO/President</u>		(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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	(Firm Name & Address) _____																																	
	(Telephone) <u>()</u> Fax # <u>()</u>																																	

Facility Name & ID Number Marklund Dreher Home

0047258 Report Period Beginning: 07/01/17 Ending: 06/30/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,787			5,787	13
14	TOTALS	5,787			5,787	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.09%

D. How many bed reserve days during this year were paid by the Department?
30 (Do not include bed reserve 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: 06/30/2018 Fiscal Year: 06/30/2018

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

Facility Name & ID Number Marklund Dreher Home # 0047258 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	21,204	1,592	3,229	26,025		26,025		26,025		1
2	Food Purchase		44,992		44,992		44,992		44,992		2
3	Housekeeping	17,211	4,251	506	21,968		21,968		21,968		3
4	Laundry	17,211	2,726		19,937		19,937		19,937		4
5	Heat and Other Utilities			21,047	21,047		21,047		21,047		5
6	Maintenance	25,013	5,341	11,628	41,982		41,982		41,982		6
7	Other (specify):* Disposal Services			1,460	1,460		1,460		1,460		7
8	TOTAL General Services	80,639	58,903	37,870	177,412		177,412		177,412		8
	B. Health Care and Programs										
9	Medical Director			4,633	4,633		4,633		4,633		9
10	Nursing and Medical Records	744,392	46,446	9,388	800,226		800,226		800,226		10
10a	Therapy	64,669	129	191	64,989		64,989		64,989		10a
11	Activities	52,280	4,777		57,057		57,057		57,057		11
12	Social Services	4,329			4,329		4,329		4,329		12
13	CNA Training										13
14	Program Transportation	6,749		8,016	14,765		14,765		14,765		14
15	Other (specify):* Vision,Dental,Pharmacy & Pysch Consultants			2,558	2,558		2,558		2,558		15
16	TOTAL Health Care and Programs	872,419	51,352	24,786	948,557		948,557		948,557		16
	C. General Administration										
17	Administrative	28,214			28,214		28,214		28,214		17
18	Directors Fees										18
19	Professional Services			7,166	7,166		7,166		7,166		19
20	Dues, Fees, Subscriptions & Promotions			6,069	6,069		6,069	(113)	5,956		20
21	Clerical & General Office Expenses	28,774	22,271	11,217	62,262	(3,809)	58,453		58,453		21
22	Employee Benefits & Payroll Taxes			246,715	246,715		246,715		246,715		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,424	2,424		2,424	(2,424)			24
25	Other Admin. Staff Transportation			4,960	4,960		4,960	(4,960)			25
26	Insurance-Prop.Liab.Malpractice			20,380	20,380		20,380		20,380		26
27	Other (specify):* Bad Debt			1,667	1,667		1,667	(1,667)			27
28	TOTAL General Administration	56,988	22,271	300,598	379,857	(3,809)	376,048	(9,164)	366,884		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,010,046	132,526	363,254	1,505,826	(3,809)	1,502,017	(9,164)	1,492,853		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			98,000	98,000		98,000	197	98,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,659	3,659		3,659	(3,659)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					3,809	3,809		3,809			35
36	Other (specify):*											36
37	TOTAL Ownership			101,659	101,659	3,809	105,468	(3,462)	102,006			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			76,405	76,405		76,405		76,405			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			76,405	76,405		76,405		76,405			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,010,046	132,526	541,318	1,683,890		1,683,890	(12,626)	1,671,264			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	(3,659)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(113)	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	(7,187)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,626)		\$	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))	\$ (12,626)		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 Dreher Home

ID# 0047258

Report Period Beginning: 07/01/17

Ending: 06/30/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Seminars	\$ (2,424)	24	1
2	Travel & Sustenance	(4,960)	25	2
3	Depreciation	197	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(7,187)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Dreher Home

0047258

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(113)	0	0	0	0	0	0	0	0	0	0	(113)	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	(2,424)	0	0	0	0	0	0	0	0	0	0	(2,424)	24
25	Other Admin. Staff Transportation	(4,960)	0	0	0	0	0	0	0	0	0	0	(4,960)	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	(9,164)	0	0	0	0	0	0	0	0	0	0	(9,164)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,164)	0	0	0	0	0	0	0	0	0	0	(9,164)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Dreher Home # 0047258 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	197	0	0	0	0	0	0	0	0	0	0	197	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,659)	0	0	0	0	0	0	0	0	0	0	(3,659)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,462)	0	0	0	0	0	0	0	0	0	0	(3,462)	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)	(12,626)	0	0	0	0	0	0	0	0	0	0	(12,626)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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	N/A	\$			\$	\$	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 Dreher Home

0047258

Report Period Beginning:

07/01/17

Ending:

06/30/18

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 Dreher Home # 0047258 Report Period Beginning: 07/01/17 Ending: 06/30/18

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 Dreher Home

0047258

Report Period Beginning:

07/01/17

Ending: 06/30/18

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	24,496,734	24,496,734	\$ 0	\$ 1,395,878	\$ 0	1
2	2	Food	Direct Cost Budget	24,496,734	24,496,734	707	1,395,878	40	2
3	3	Housekeeping	Direct Cost Budget	24,496,734	24,496,734	4,077	1,395,878	232	3
4	5	Utilities	Direct Cost Budget	24,496,734	24,496,734	26,257	1,395,878	1,496	4
5	6	Maintenance	Direct Cost Budget	24,496,734	24,496,734	13,396	1,395,878	763	5
6	7	Disposal	Direct Cost Budget	24,496,734	24,496,734	1,114	1,395,878	63	6
7	13	BNATP	Direct Cost Budget	24,496,734	24,496,734	0	1,395,878	0	7
8	14	Transportation	Direct Cost Budget	24,496,734	24,496,734	0	1,395,878	0	8
9	19	Professional Services	Direct Cost Budget	24,496,734	24,496,734	92,750	1,395,878	5,285	9
10	20	Fees,Subscription	Direct Cost Budget	24,496,734	24,496,734	78,979	1,395,878	4,500	10
11	21	Clerical/Office	Direct Cost Budget	24,496,734	24,496,734	361,403	1,395,878	20,594	11
12	22	Benefits	Direct Cost Budget	24,496,734	24,496,734	117,972	1,395,878	6,722	12
13	24	Travel & Seminar	Direct Cost Budget	24,496,734	24,496,734	14,043	1,395,878	800	13
14	25	Staff Transportation	Direct Cost Budget	24,496,734	24,496,734	9,502	1,395,878	541	14
15	26	Insurance	Direct Cost Budget	24,496,734	24,496,734	25,548	1,395,878	1,456	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 745,748	\$	\$ 42,492	25

Facility Name & ID Number

Marklund Dreher Home

0047258

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Dreher Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047258

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(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>Residential - Tax exempt</u>	\$ _____	\$ _____
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Dreher Home

0047258 Report Period Beginning:

07/01/17 Ending:

06/30/18

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? (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 Sayers Home 16 bed facility 8315 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	<u>Patient care</u>	<u>116,479</u>	<u>2006</u>	<u>\$ 550,105</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	116,479		\$ 550,105	3

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	\$	\$ 877,672	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LI ADD'L 16-BED HOMES -#5		2006	42,499		10			42,499	9
10		LI ADD'L MILL CREEK 16-BED HOMES		2006	159,630		10			159,630	10
11		LI Repairs to Asphalt Path		2006	1,410		5			1,410	11
12		BI CORIAN COUNTER TOP REPLACEMENT		2007	1,130		5			1,130	12
13		BI LIGHTNING PROTECTION SYSTEM		2008	3,100		5			3,100	13
14		BI Corian Repair - Nurses' Desk		2008	500		5			500	14
15		LI SEALCOATING DRIVEWAY/SIDEWALKS		2008	1,525		2			1,525	15
16		LI HOT RUBBER CRACKFILL REPAIR		2008	427		2			427	16
17		LI TRASH ENCLOSURE FENCE REPAIR		2008	447		5			447	17
18		LI INSTALLATION OF 2 BOLLARD LGHT		2008	637		5			637	18
19		LI REPLACEMENT OF DUMPSTER GATE		2010	166		5			166	19
20		LI REPLACE ASPHALT SIDEWALKS		2010	4,667	467	10	467		3,500	20
21		LI Asphalt Repairs-North Approach		2011	1,217		5			1,217	21
22		LI Replacement-Asphalt Sidewalks		2011	4,501	450	10	450		3,376	22
23		LI Asphalt Repairs near Ballfield		2011	163		5			163	23
24		BI REPLACEMENT OF DOOR FRAME		2012	1,639		5			1,639	24
25		LI REFURBISHING OF EXTERIOR SIGNS		2012	1,664		5			1,664	25
26		LI Wheelchair Glider w/Concrete		2012	1,562	156	5	156		1,562	26
27		BI HARDI-TRIM REPLACEMENT-PATIO		2013	1,075	108	5	108		1,075	27
28		LI CONCRETE REPLACEMENT -Patio		2013	2,344	234	5	234		2,344	28
29		LI CONCRETE REPLACEMENT OF		2013	2,833	283	10	283		1,275	29
30		LI PHASE III - REPLACE ASPHALT		2014	4,017	402	10	402		1,406	30
31		LI Dreher Home Exterior Sign		2014	1,850	370	5	370		1,295	31
32		BI Lamp Flourescent drum fixtures		2016	822	78	10	78		238	32
33		BI Data line Install 10 line 5dp		2016	78	8	10	8		12	33
34		BI Electric Outlet Orient Room		2016	169	8	20	8		13	34
35		BI CARPETING-NEW ORIENTAION ROOM		2016	288	58	5	58		86	35
36		LI Trash Enclosure Repair		2016	1,955	244	8	244		367	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 Dreher Home

0047258

Report Period Beginning:

07/01/17

Ending:

06/30/18

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	LI Sink Hole Rpr Baseball Fld	2017	\$ 417	\$ 35	12	\$ 35	\$	\$ 52	37
38	LI Outdoor Signage New Logo	2017	1,697	71	12	71		71	38
39	BI LED Fixture Replac, Recep Relo	2017	1,150	58	10	58		58	39
40	LI Sink Hole Repair Baseball Fld	2017	983	41	12	41		41	40
41	LI Grind and Repavement	2017	712	24	15	24		24	41
42	BI Flooring	2018	3,880	194	10	194		194	42
43	LI Sealcoating, Crackfl Strip Pk	2018	1,482	370	2	370		370	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)		\$ 1,656,911	\$ 73,873		\$ 73,873	\$	\$ 1,111,185	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	\$ 87,222	\$ 14,525	\$ 14,525	\$		\$ 67,984	71
72	Current Year Purchases	12,264	1,235	1,235			1,235	72
73	Fully Depreciated Assets	180,868					180,868	73
74								74
75	TOTALS	\$ 280,354	\$ 15,760	\$ 15,760	\$		\$ 250,087	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	\$ 5,866	\$ 5,866	\$	5	\$ 14,665	76
77	Patient Transport	2017 Ford El Dorado Bus	2018	10,435	1,043	1,043		5	1,044	77
78	Patient Transport	2014 Ford Ambulette 1/6	2015	5,976	1,196	1,196		5	4,184	78
79	Maintenance	2013 Ford SD Pickup Truck	2013	4,586	459	459		5	4,586	79
80	TOTALS			\$ 50,327	\$ 8,564	\$ 8,564	\$		\$ 24,479	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)	\$ 2,537,697	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,197	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,197	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)	\$ 1,385,751	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 Dreher Home

0047258

Report Period Beginning: 07/01/17

Ending: 06/30/18

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 3,809

Description: Office Equipment/Machinery

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 37,509,804	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 37,509,804	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(181,333)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,720,432	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Remaining Consolidated Income	(1,419,771)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 119,328	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- Exp.	1,223,840	18
19	Transfers out of Restricted Funds into Operations-Capital	1,095,562	19
20	Transfers into Operations from Restricted Funds	(1,095,562)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,223,840	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 38,852,972	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,343,986	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,343,986	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	9,981	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)	\$ 9,981	23
D. Non-Operating Revenue			
24	Contributions	46,931	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,931	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)	\$ 1,400,898	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	177,412	31
32	Health Care	948,557	32
33	General Administration	379,857	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	76,405	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,582,231	40
41	Income before Income Taxes (line 30 minus line 40)**	(181,333)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (181,333)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,220,894	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	123,092	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,343,986	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 Dreher Home

0047258

Report Period Beginning: 07/01/17

Ending: 06/30/18

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	\$ 12,460	\$ 42.79	1
2	Assistant Director of Nursing	988	37,096	35.67	2
3	Registered Nurses	6,422	196,851	29.12	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	26,044	462,207	16.86	5
6	CNA Trainees				6
7	Licensed Therapist	1,601	59,820	35.51	7
8	Rehab/Therapy Aides	277	4,849	16.65	8
9	Activity Director	178	4,295	22.94	9
10	Activity Assistants	2,964	47,986	15.38	10
11	Social Service Workers	257	4,329	16.01	11
12	Dietician				12
13	Food Service Supervisor	336	8,213	23.23	13
14	Head Cook	316	5,643	16.96	14
15	Cook Helpers/Assistants	316	3,674	11.04	15
16	Dishwashers	316	3,674	11.04	16
17	Maintenance Workers	810	25,013	29.33	17
18	Housekeepers	1,324	17,211	12.35	18
19	Laundry	1,324	17,211	12.35	19
20	Administrator	316	17,023	51.15	20
21	Assistant Administrator	336	11,191	31.65	21
22	Other Administrative	165	21,658	125.00	22
23	Office Manager				23
24	Clerical	435	7,116	15.54	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,482	31,118	19.95	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	277	4,659	16.01	31
32	Other Health Care(specify)	494	6,749	12.98	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	47,253	\$ 1,010,046 *	\$ 20.31	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	42	\$ 2,096	1 35
36	Medical Director	Monthly	4,633	9 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Varies	789	15 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	3	191	10a 42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Psychologist</u>	9	723	15 46
47	<u>Vision</u>	Visit	251	15 47
48	<u>Dental</u>	Visit	795	15 48
49	TOTAL (lines 35 - 48)	53	\$ 9,478	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	25	\$ 1,122	10 50
51	Licensed Practical Nurses	43	1,207	10 51
52	Certified Nurse Assistants/Aides	300	7,059	10 52
53	TOTAL (lines 50 - 52)	368	\$ 9,388	53

Facility Name & ID Number Marklund Dreher Home# 0047258Report Period Beginning: 07/01/17Ending: 06/30/18**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 , \$936
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 16,963 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. \$ 76,405
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? N/A
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. YES
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	MDH