



Facility Name & ID Number Marklund Dreher Home

# 0047258 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

**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	5,699			5,699	13
14	TOTALS	5,699			5,699	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 97.32%

**D. How many bed reserve days during this year were paid by the Department?**  
18 (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: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number Marklund Dreher Home # 0047258 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

**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	18,069	1,370	2,417	21,856		21,856		21,856		1
2	Food Purchase		45,911		45,911		45,911		45,911		2
3	Housekeeping	53,869	5,209	5,882	64,960		64,960		64,960		3
4	Laundry	19,793	3,063		22,856		22,856		22,856		4
5	Heat and Other Utilities			21,949	21,949		21,949		21,949		5
6	Maintenance	36,372	5,323	12,173	53,868		53,868		53,868		6
7	Other (specify):* <b>Disposal Services</b>			1,753	1,753		1,753		1,753		7
8	<b>TOTAL General Services</b>	128,103	60,876	44,174	233,153		233,153		233,153		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,667	3,667		3,667		3,667		9
10	Nursing and Medical Records	754,493	48,471	30,181	833,145		833,145		833,145		10
10a	Therapy	114,388	1,232	263	115,883		115,883		115,883		10a
11	Activities	8,736	2,750		11,486		11,486		11,486		11
12	Social Services	4,999			4,999		4,999		4,999		12
13	CNA Training		243		243		243		243		13
14	Program Transportation	2,808		3,763	6,571		6,571		6,571		14
15	Other (specify):* <b>Vision,Dental,Pharmacy &amp; Pysch Consultants</b>			3,884	3,884		3,884		3,884		15
16	<b>TOTAL Health Care and Programs</b>	885,424	52,696	41,758	979,878		979,878		979,878		16
	<b>C. General Administration</b>										
17	Administrative	25,611			25,611		25,611		25,611		17
18	Directors Fees										18
19	Professional Services			9,024	9,024		9,024	(3,427)	5,597		19
20	Dues, Fees, Subscriptions & Promotions			8,824	8,824		8,824	(2,548)	6,276		20
21	Clerical & General Office Expenses	42,254	27,371	9,519	79,144	(4,423)	74,721		74,721		21
22	Employee Benefits & Payroll Taxes			291,707	291,707		291,707		291,707		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,645	1,645		1,645	(1,137)	508		24
25	Other Admin. Staff Transportation			901	901		901	(1,409)	(508)		25
26	Insurance-Prop.Liab.Malpractice			20,274	20,274		20,274		20,274		26
27	Other (specify):* <b>Bad Debt</b>			1,623	1,623		1,623	(1,623)			27
28	<b>TOTAL General Administration</b>	67,865	27,371	343,517	438,753	(4,423)	434,330	(10,144)	424,186		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,081,392	140,943	429,449	1,651,784	(4,423)	1,647,361	(10,144)	1,637,217		29

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

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

Facility Name &amp; ID Number

Marklund Dreher Home

#0047258

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			99,082	99,082		99,082	(1,958)	97,124			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			971	971		971	(971)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					4,423	4,423		4,423			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			100,053	100,053	4,423	104,476	(2,929)	101,547			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			82,340	82,340		82,340		82,340			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			82,340	82,340		82,340		82,340			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,081,392	140,943	611,842	1,834,177		1,834,177	(13,073)	1,821,104			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	(971)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(450)	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	(3,427)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,623)	27		24
25	Fund Raising, Advertising and Promotional	(2,098)	20		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	(4,504)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (13,073)		\$	30

BHF USE ONLY							
48		49		50		51	

**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>	\$ (13,073)		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

Marklund Dreher Home

ID# 0047258

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Seminars	\$ (1,137)	24	1
2	Travel & Sustenance	(1,409)	25	2
3	Depreciation	(1,958)	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	<b>Total</b>	(4,504)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Dreher Home# 0047258

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

## 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>	<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>8</b>
	<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>	<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>16</b>
	<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	(3,427)	0	0	0	0	0	0	0	0	0	0	(3,427)	19
20	Fees, Subscriptions & Promotions	(2,548)	0	0	0	0	0	0	0	0	0	0	(2,548)	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	(1,137)	0	0	0	0	0	0	0	0	0	0	(1,137)	24
25	Other Admin. Staff Transportation	(1,409)	0	0	0	0	0	0	0	0	0	0	(1,409)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,623)	0	0	0	0	0	0	0	0	0	0	(1,623)	27
28	<b>TOTAL General Administration</b>	<b>(10,144)</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>(10,144)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(10,144)</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>(10,144)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Dreher Home# 0047258

Report Period Beginning:

07/01/2019 Ending:06/30/2020

## 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	(1,958)	0	0	0	0	0	0	0	0	0	0	(1,958) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(971)	0	0	0	0	0	0	0	0	0	0	(971) 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	<b>TOTAL Ownership</b>	<b>(2,929)</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>(2,929) 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 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(13,073)</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>(13,073) 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	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.

**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	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								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 &amp; ID Number

Marklund Dreher Home

# 0047258

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

## 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:

07/01/2019

Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	28,436,542	28,436,542	\$ 63	\$ 1,624,203	\$ 4	1
2	2	Food	Direct Cost Budget	28,436,542	28,436,542	977	1,624,203	56	2
3	3	Housekeeping	Direct Cost Budget	28,436,542	28,436,542	4,584	1,624,203	262	3
4	5	Utilities	Direct Cost Budget	28,436,542	28,436,542	24,863	1,624,203	1,420	4
5	6	Maintenance	Direct Cost Budget	28,436,542	28,436,542	18,017	1,624,203	1,029	5
6	7	Disposal	Direct Cost Budget	28,436,542	28,436,542	1,292	1,624,203	74	6
7	13	BNATP	Direct Cost Budget	28,436,542	28,436,542	1,559	1,624,203	89	7
8	14	Transportation	Direct Cost Budget	28,436,542	28,436,542	0	1,624,203	0	8
9	19	Professional Services	Direct Cost Budget	28,436,542	28,436,542	98,000	1,624,203	5,597	9
10	20	Fees,Subscription	Direct Cost Budget	28,436,542	28,436,542	124,826	1,624,203	7,130	10
11	21	Clerical/Office	Direct Cost Budget	28,436,542	28,436,542	1,051,451	627,717	60,055	11
12	22	Benefits	Direct Cost Budget	28,436,542	28,436,542	169,328	1,624,203	9,671	12
13	24	Travel & Seminar	Direct Cost Budget	28,436,542	28,436,542	6,943	1,624,203	397	13
14	25	Staff Transportation	Direct Cost Budget	28,436,542	28,436,542	4,837	1,624,203	276	14
15	26	Insurance	Direct Cost Budget	28,436,542	28,436,542	32,682	1,624,203	1,867	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,539,422	\$ 627,717	\$ 87,927	25

Facility Name & ID Number

Marklund Dreher Home

# 0047258

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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																			
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	n/a																			
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$	\$		\$											
<b>B. Non-Facility Related*</b>																				
10	n/a																			
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$											
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$											

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 2019 report.

\$

1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$

2

3. Under or (over) accrual (line 2 minus line 1).

\$

3

4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)

\$

4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$

5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ \_\_\_\_\_ For \_\_\_\_\_ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$

6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$

7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2015	_____	8
2016	_____	9
2017	_____	10
2018	_____	11
2019	_____	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**



Facility Name & ID Number Marklund Dreher Home

# 0047258 Report Period Beginning:

07/01/2019 Ending:

06/30/2020

**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	Patient care	116,479	2006	\$ 550,105	1
2					2
3	TOTALS	116,479		\$ 550,105	3



Facility Name &amp; ID Number Marklund Dreher Home

# 0047258

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

**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	\$	\$ 1,018,100	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LI Marklund Dreher Home		2006	42,499		10			42,499	9
10	LI Marklund Dreher Home Land		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	LI HOT RUBBER CRACKFILL REPAIR		2008	427		2			427	13
14	LI SEALCOATING DRIVEWAY/SIDEWALKS		2008	1,525		2			1,525	14
15	BI LIGHTNING PROTECTION SYSTEM		2008	3,100		5			3,100	15
16	LI TRASH ENCLOSURE FENCE REPAIR		2008	447		5			447	16
17	LI INSTALLATION OF 2 BOLLARD LGHT		2008	637		5			637	17
18	BI Corian Repair - Nurses' Desk		2008	500		5			500	18
19	LI REPLACEMENT OF DUMPSTER GATE		2010	166		5			166	19
20	LI REPLACE ASPHALT SIDEWALKS WITH		2010	4,667	467	10	467		4,433	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		4,276	22
23	LI Asphalt Repairs near Ballfield		2011	163		5			163	23
24	LI REFURBISHING OF EXTERIOR SIGNS		2012	1,664		5			1,664	24
25	BI REPLACEMENT OF DOOR FRAME &		2012	1,639		5			1,639	25
26	LI Wheelchair Glider w/Concrete		2012	1,562		5			1,562	26
27	CONCRETE REPLACEMENT -Patio		2013	2,344		5			2,344	27
28	BI HARDI-TRIM REPLACEMENT-PATIO		2013	1,075		5			1,075	28
29	LI CONCRETE REPLACEMENT OF		2013	2,833	283	10	283		1,842	29
30	LI PHASE III - REPLACE ASPHALT		2014	4,017	402	10	402		2,209	30
31	LI Dreher Home Exterior Sign		2014	1,850	185	5	185		1,850	31
32	BI Lamp Flourescent drum fixtures		2016	822	78	5	78		394	32
33	LI Trash Enclosure Repair		2016	1,955	244	8	244		855	33
34	BI Data line Install 10 line 5dp		2016	78	8	10	8		27	34
35	BI Electric Outlet Orient Room &		2016	169	8	20	8		30	35
36	BI CARPETING-NEW ORIENTAION ROOM		2016	288	58	5	58		201	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	2	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	\$	\$ 122	37
38	LI Outdoor Signage New Logo	2017	1,697	141	12	141		354	38
39	BI LED Fixture Replac, Recep Relo	2017	1,150	115	10	115		288	39
40	LI Sink Hole Repair Baseball Fld	2017	983	82	12	82		205	40
41	LI Grind and Repavement	2017	712	47	15	47		119	41
42	BI Flooring	2018	3,880	388	10	388		970	42
43	LI Sealcoating, Crackfl Strip Pk	2018	1,482	370	2	370		1,482	43
44	LI Replace Fence Posts Spt Evenly	2019	283	57	5	57		85	44
45	BI Window Blind Replacement	2019	318	32	5	32		32	45
46	BI Interior Painting Bedrooms	2019	4,835	484	5	484		484	46
47	BI Carpet Replacement w/Flotex	2019	41,566	4,157	5	4,157		4,157	47
48	BI Repair 4' kitchen flr pipe brk	2019	1,583	79	10	79		79	48
49	BI Washine Machine Waterline Rep	2020	208	21	5	21		21	49
50	BI Panic Button System Splt Homes	2020	801	80	5	80		80	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,706,505	\$ 78,485		\$ 78,485	\$	\$ 1,263,830	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	\$ 45,624	\$ 9,056	\$ 9,056	\$	5	\$ 29,625	71
72	Current Year Purchases	19,545	2,004	2,004		5	2,004	72
73	Fully Depreciated Assets	228,876	983	983		5	228,876	73
74								74
75	TOTALS	\$ 294,045	\$ 12,043	\$ 12,043	\$		\$ 260,505	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	Maintenance	2013 Ford F250 Pickup 1/6	2013	\$ 4,586	\$	\$	\$	5	\$ 4,586	76
77	Patient Transport	2014 Ford Ambulette Van 1/6	2014	5,978	598	598		5	5,978	77
78	Patient Transport	2016 Ford E350 Bus 1/3	2016	19,553	3,911	3,911		5	17,598	78
79	Patient Transport	2017 El Dorado Bus 1/6	2018	10,435	2,087	2,087		5	5,217	79
80	TOTALS			\$ 40,552	\$ 6,596	\$ 6,596	\$		\$ 33,379	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)	\$ 2,591,207	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,124	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)	\$ 1,557,714	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: 07/01/2019

Ending: 06/30/2020

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: n/a

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 4,423

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	<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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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 Dreher Home

# 0047258

Report Period Beginning: 07/01/2019

Ending:

06/30/2020

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2020

(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	\$ 6,348,539	\$ 6,348,539	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 319,818 )	4,633,727	4,633,727	3
4	Supply Inventory (priced at )	91,805	91,805	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	330,340	330,340	7
8	Accounts Receivable (owners or related parties)	709,603	709,603	8
9	Other(specify): <u>Client Related Accounts</u>	477,230	477,230	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 12,591,244	\$ 12,591,244	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	1,282,287	1,282,287	11
12	Long-Term Investments			12
13	Land	7,918,001	7,918,001	13
14	Buildings, at Historical Cost	29,694,293	29,694,293	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,300,602	6,300,602	16
17	Accumulated Depreciation (book methods)	(26,678,871)	(26,678,871)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,888,230	10,888,230	21
22	Other Long-Term Assets (spe <u>PPP loan &amp; other</u>	8,613,855	8,613,855	22
23	Other(specify): <u>construction in progress</u>	9,921,644	9,921,644	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 47,940,041	\$ 47,940,041	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 60,531,285	\$ 60,531,285	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 294,114	\$ 294,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	272,816	272,816	29
30	Accrued Salaries Payable	856,741	856,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,115	63,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,263,189	1,263,189	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Construction payables</u>	1,047,238	1,047,238	36
37	<u>Misc. Other</u>	2,058,701	2,058,701	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,855,913	\$ 5,855,913	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	6,274,768	6,274,768	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Paycheck Protection Program loan</u>	3,879,650	3,879,650	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 10,154,418	\$ 10,154,418	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 16,010,331	\$ 16,010,331	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 44,520,954	\$ 44,520,954	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 60,531,285	\$ 60,531,285	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>39,797,188</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>39,797,188</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(281,920)	<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	872,412	<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>	4,086,936	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>4,677,428</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>transfers out in to operations-expenses</b>	46,338	<b>18</b>
<b>19</b>	<b>transfers out in to operations-capial</b>	2,872,497	<b>19</b>
<b>20</b>	<b>transfers out in to operations-capial</b>	(2,872,497)	<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>	\$ <b>46,338</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>44,520,954</b>	<b>24</b> *

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



Facility Name &amp; ID Number Marklund Dreher Home

# 0047258

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

**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	\$ 1,486,446	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,486,446	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	12,276	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>	\$ 12,276	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	53,535	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 53,535	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>	\$ 1,552,257	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	233,153	31
32	Health Care	979,878	32
33	General Administration	438,753	33
<b>B. Capital Expense</b>			
34	Ownership	100,053	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	82,340	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,834,177	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(281,920)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (281,920)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,350,445	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	136,001	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,486,446	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: 07/01/2019

Ending: 06/30/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	276	\$ 12,600	\$ 43.30	1
2	Assistant Director of Nursing	1,378	49,183	33.92	2
3	Registered Nurses	5,312	169,167	30.25	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	24,045	461,912	18.25	5
6	CNA Trainees				6
7	Licensed Therapist	1,680	74,530	42.15	7
8	Rehab/Therapy Aides	2,075	39,858	18.25	8
9	Activity Director	296	8,736	28.00	9
10	Activity Assistants				10
11	Social Service Workers	164	4,999	28.90	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	316	7,688	23.09	14
15	Cook Helpers/Assistants	362	5,722	15.02	15
16	Dishwashers	316	4,659	13.99	16
17	Maintenance Workers	1,178	36,372	29.33	17
18	Housekeepers	3,529	53,869	14.50	18
19	Laundry	1,220	19,793	15.42	19
20	Administrator	296	17,325	55.53	20
21	Assistant Administrator	296	8,287	26.56	21
22	Other Administrative	99	13,584	130.62	22
23	Office Manager				23
24	Clerical	1,152	28,669	23.63	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,976	57,013	27.41	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	247	4,618	17.76	31
32	Other Health Care(specify)	198	2,808	13.50	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	46,411	\$ 1,081,392 *	\$ 22.13	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	40	\$ 2,025	1	35
36	Medical Director	monthly	3,667	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	1,573	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	263	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	14	1,179	15	46
47	<u>Vision</u>	visit	270	15	47
48	<u>Dental</u>	visit	862	15	48
49	TOTAL (lines 35 - 48)	58	\$ 9,839		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	36	\$ 1,699	10	50
51	Licensed Practical Nurses	44	2,000	10	51
52	Certified Nurse Assistants/Aides	1,061	26,482	10	52
53	TOTAL (lines 50 - 52)	1,141	\$ 30,181		53



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. Illinois Healthcare Association , \$953
- (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. \$ 17,651 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. \$ 82,340  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? n/a Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
  - c. What percent of all travel expense relates to transportation of nurses and patients? 0
  - d. Have vehicle usage logs been maintained? yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
  - 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.

page 14, item 16

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Canon	IR4535III	1

**2020 Marklund Board of Directors**

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