

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0047266</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Markund Richard Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/10</u> to <u>06/30/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1S410 Wyatt Drive</u> <u>Geneva</u> <u>60134</u>																																																	
Number City Zip Code																																																	
County: <u>Kane</u>																																																	
Telephone Number: <u>(630) 593-5500</u> Fax # <u>(630) 593-5501</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Gilbert W. Fonger</u></td></tr><tr><td>(Title) <u>President/ CEO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</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>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Gilbert W. Fonger</u>	(Title) <u>President/ CEO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																																			
Officer or Administrator of Provider	(Signed) _____																																																
	(Type or Print Name) <u>Gilbert W. Fonger</u>																																																
	(Title) <u>President/ CEO</u>																																																
	(Date) _____																																																
Paid Preparer	(Signed) _____																																																
	(Date) _____																																																
	(Print Name and Title) _____																																																
	(Firm Name & Address) _____																																																
	(Telephone) <u>()</u> Fax # <u>()</u>																																																
Date of Initial License for Current Owners: _____																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 (c) 3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 (c) 3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____	
☒	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																												
☒	Charitable Corp.	☐	Individual	☐	State																																												
☐	Trust	☐	Partnership	☐	County																																												
IRS Exemption Code <u>501 (c) 3</u>		☐	Corporation	☐	Other _____																																												
		☐	"Sub-S" Corp.	_____																																													
		☐	Limited Liability Co.	_____																																													
		☐	Trust	_____																																													
		☐	Other	_____																																													
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Lynn Melvin</u>																																																	
Telephone Number: <u>(630) 593-5485</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Markund Richard Home

0047266 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	5,738	0	0	5,738	13
14	TOTALS	5,738			5,738	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.25%

D. How many bed-hold days during this year were paid by the Department? 18 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date 06/16/06 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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/11 Fiscal Year: 06/30/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Markund Richard Home # 0047266 Report Period Beginning: 07/01/10 Ending: 06/30/11
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	27,726	1,550	3,885	33,161		33,161		33,161			1
2	Food Purchase		49,042		49,042		49,042		49,042			2
3	Housekeeping	13,936	5,689	17	19,642		19,642		19,642			3
4	Laundry	11,860	2,113		13,973		13,973		13,973			4
5	Heat and Other Utilities			27,238	27,238		27,238		27,238			5
6	Maintenance	12,240	4,996	13,420	30,656		30,656		30,656			6
7	Other (specify):* DISPOSAL			3,814	3,814		3,814		3,814			7
8	TOTAL General Services	65,762	63,390	48,374	177,526		177,526		177,526			8
	B. Health Care and Programs											
9	Medical Director			3,667	3,667		3,667		3,667			9
10	Nursing and Medical Records	638,405	35,401	9,723	683,529		683,529		683,529			10
10a	Therapy	37,137	750	25	37,912		37,912		37,912			10a
11	Activities	27,780	3,171		30,951		30,951		30,951			11
12	Social Services	3,326			3,326		3,326		3,326			12
13	CNA Training		49		49		49		49			13
14	Program Transportation	9,485		18,212	27,697		27,697		27,697			14
15	Other (specify):* VIS/DEN/RX/PSY			2,202	2,202		2,202		2,202			15
16	TOTAL Health Care and Programs	716,133	39,371	33,829	789,333		789,333		789,333			16
	C. General Administration											
17	Administrative	48,363			48,363		48,363		48,363			17
18	Directors Fees											18
19	Professional Services			3,847	3,847		3,847	(922)	2,925			19
20	Dues, Fees, Subscriptions & Promotions			6,849	6,849		6,849	(3,515)	3,334			20
21	Clerical & General Office Expenses	40,513	18,591	5,543	64,647	(2,968)	61,679		61,679			21
22	Employee Benefits & Payroll Taxes			156,979	156,979		156,979		156,979			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,809	2,809		2,809	(2,809)				24
25	Other Admin. Staff Transportation			1,317	1,317		1,317	(1,317)				25
26	Insurance-Prop.Liab.Malpractice			29,919	29,919		29,919		29,919			26
27	Other (specify):* FUND RAISING/PROMO			1,666	1,666		1,666	(1,666)				27
28	TOTAL General Administration	88,876	18,591	208,929	316,396	(2,968)	313,428	(10,229)	303,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	870,771	121,352	291,132	1,283,255	(2,968)	1,280,287	(10,229)	1,270,058			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			120,298	120,298		120,298	(7,866)	112,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,121	2,121		2,121	(2,121)				32
33	Real Estate Taxes			2	2		2	(2)	0			33
34	Rent-Facility & Grounds			9,316	9,316		9,316	(9,316)	(0)			34
35	Rent-Equipment & Vehicles					2,968	2,968		2,968			35
36	Other (specify):*											36
37	TOTAL Ownership			131,737	131,737	2,968	134,705	(19,305)	115,400			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			70,267	70,267		70,267		70,267			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			70,267	70,267		70,267		70,267			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	870,771	121,352	493,136	1,485,259		1,485,259	(29,534)	1,455,725			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,121)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,515)	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	(922)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,666)	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	(21,310)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,534)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (29,534)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Markund Richard Home

ID# 0047266

Report Period Beginning: 07/01/10

Ending: 06/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Seminars	\$ (2,809)	24	1
2	Travel & Sustenance	(1,317)	25	2
3	Depreciation	(7,866)	30	3
4	Real Estate Taxes	(2)	33	4
5	Rent	(9,316)	34	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,310)		49

Summary A

06/30/11

[illegible]

Summary B

06/30/11

[illegible]

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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

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

Ending: 06/30/11

Fax Number

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	13,062,145	13062144.66	\$ 27	\$	1,204,871	\$ 3	1
2	2	Food	Direct Cost Budget	13,062,145	13062144.66	1,294		1,204,871	119	2
3	3	Housekeeping	Direct Cost Budget	13,062,145	13062144.66	6,825		1,204,871	630	3
4	5	Utilities	Direct Cost Budget	13,062,145	13062144.66	60,561		1,204,871	5,586	4
5	6	Maintenance	Direct Cost Budget	13,062,145	13062144.66	18,276		1,204,871	1,686	5
6	7	Disposal	Direct Cost Budget	13,062,145	13062144.66	10,922		1,204,871	1,007	6
7	13	BNATP	Direct Cost Budget	13,062,145	13062144.66	300		1,204,871	28	7
8	14	Transportation	Direct Cost Budget	13,062,145	13062144.66	6,119		1,204,871	564	8
9	19	Professional Services	Direct Cost Budget	13,062,145	13062144.66	31,710		1,204,871	2,925	9
10	20	Fees,Subscriptions	Direct Cost Budget	13,062,145	13062144.66	26,620		1,204,871	2,455	10
11	21	Clerical/Office	Direct Cost Budget	13,062,145	13062144.66	194,478		1,204,871	17,939	11
12	22	Benefits	Direct Cost Budget	13,062,145	13062144.66	87,257		1,204,871	8,049	12
13	24	Travel & Seminar	Direct Cost Budget	13,062,145	13062144.66	15,926		1,204,871	1,469	13
14	25	Staff Transportation	Direct Cost Budget	13,062,145	13062144.66	6,841		1,204,871	631	14
15	26	Insurance	Direct Cost Budget	13,062,145	13062144.66	23,097		1,204,871	2,130	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 490,253	\$		\$ 45,221	25

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					
	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.)

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 2010 report.		\$	N/A		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$	#VALUE!		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	#VALUE!		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

FACILITY NAME	<u>Markund Richard Home</u>	COUNTY	<u>Kane</u>
FACILITY IDPH LICENSE NUMBER	<u>0047266</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Kodus Badmus</u>		
TELEPHONE	(630) 593-5487	FAX #:	(630) 593-5501

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,815

B. General Construction Type: Exterior Brick/CedarFrame Wood/SteelNumber 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 CenterDay Training43,000 Square Feet102 Person Capacity

Marklund Haverkamp Home16-Bed Facility8,315 Square Feet16 Person Capacity

Marklund VanDerMolen Home16-Bed Facility8,315 Square Feet16 Person Capacity

Marklund Tommy Home16-Bed Facility8,315 Square Feet16 Person Capacity

Marklund Sayers Home16-Bed Facility8,315 Square Feet16 Person Capacity

Marklund Mill Creek Home 316-Bed Facility8,815 Square Feet16 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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care		2004	\$ 329,981	1
2					2
3	TOTALS			\$ 329,981	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		\$ 386,176
5			2006	2006	106,795	10,679	10	10,679		58,737
6			2006	2006	42,499	4,250	10	4,250		23,374
7										
8										
	Improvement Type**									
9	LI	Single-faced sandblasted cedar signage		2007	1,450	290	5	290		1,305
10	BI	Lightning Protection System		2008	3,100	620	5	620		2,170
11	LI	Hot Rubber Crackfill Repair		2008	427		2			427
12	LI	Sealcoating Driveway/Sidewalks		2008	1,525		2			1,525
13	LI	Trash Enclosure Fence Repair		2009	447	89	5	89		223
14	LI	Installation of 2 Bollard Lights		2009	637	127	5	127		319
15	LI	Replacement of dumpster gate		2010	166	33	5	33		50
16	LI	Asphalt Repairs -North Appraoch to NE Parking Lot		2011	1,217	122	5	122		122
17	LI	Replacement-Asphalt sidewalk w/concrete		2011	4,501	225	10	225		225
18	LI	Replace Asphalt Sidewalks w/Concrete		2011	4,667	233	10	233		233
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,571,705	\$86,882		\$86,882	\$	\$474,886	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	\$155,070	\$18,968	\$18,968	\$		\$135,454	71
72	Current Year Purchases	9,339	884	884			884	72
73	Fully Depreciated Assets	12,797					12,797	73
74								74
75	TOTALS	\$177,206	\$19,852	\$19,852	\$		\$149,134	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2008 Ford Eldorado (1/2)	2008	\$24,925	\$4,985	\$4,985	\$	5	\$17,448	76
77	Snow Plow	2003 Ford F350 (1/6)	2003	5,248				5	5,248	77
78	Maintenance	2004 F250 (1/6)	2004	2,834				5	2,834	78
79	Laundry Van/General Use	2008 Ford Cargo Van (1/6)	2008	3,563	713	713		5	2,494	79
80	TOTALS			\$36,570	\$5,698	\$5,698	\$		\$28,023	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$2,115,462	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$112,432	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$112,432	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)	\$652,043	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.

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	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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: \$ 2,968
- 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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

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

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number	Markund Richard Home
--------------------------------------	-----------------------------

0047266

Report Period Beginning: 07/01/10

Ending: 06/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/11

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 731,969	\$ 731,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>184,000</u>)	3,195,562	3,195,562	3
4	Supply Inventory (priced at _____)	71,593	71,593	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	70,344	70,344	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	606,808	606,808	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,676,276	\$ 4,676,276	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,420,768	6,420,768	13
14	Buildings, at Historical Cost	22,601,817	22,601,817	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,422,739	4,422,739	16
17	Accumulated Depreciation (book methods)	(15,097,363)	(15,097,363)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,929,876	5,929,876	21
22	Other Long-Term Assets (specify): _____	4,324,534	4,324,534	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,602,371	\$ 28,602,371	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,278,647	\$ 33,278,647	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 224,437	\$ 224,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,279	100,279	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,149	9,149	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	compensation & related payables	1,209,317	1,209,317	36
37	misc. other	2,829,053	2,829,053	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,372,235	\$ 4,372,235	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,372,235	\$ 4,372,235	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,893,214	\$ 28,893,214	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,265,449	\$ 33,265,449	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 28,388,980	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 28,388,980	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(179,517)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	466,519	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	241,875	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 528,877	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- exp.	(24,643)	18
19	Transfers out of Restricted Funds into Operations-capital	(208,815)	19
20	Transfers into Operations from Restricted Funds	208,815	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (24,643)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 28,893,214	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,273,004	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,273,004	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	32,739	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,739	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)	\$ 1,305,743	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	177,526	31
32	Health Care	789,333	32
33	General Administration	316,396	33
	B. Capital Expense		
34	Ownership	131,737	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	70,267	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,485,259	40
41	Income before Income Taxes (line 30 minus line 40)**	(179,517)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (179,517)	43

* 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	277	291	\$ 11,566	\$ 39.75	1
2	Assistant Director of Nursing	1,976	2,080	55,432	26.65	2
3	Registered Nurses	6,896	7,259	207,360	28.57	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	22,823	24,024	329,466	13.71	5
6	CNA Trainees					6
7	Licensed Therapist	692	728	23,871	32.79	7
8	Rehab/Therapy Aides	632	666	13,265	19.92	8
9	Activity Director					9
10	Activity Assistants	2,371	2,496	27,780	11.13	10
11	Social Service Workers	257	270	3,326	12.32	11
12	Dietician					12
13	Food Service Supervisor	494	520	11,586	22.28	13
14	Head Cook	652	686	9,953	14.51	14
15	Cook Helpers/Assistants	336	354	3,182	8.99	15
16	Dishwashers	336	354	3,006	8.49	16
17	Maintenance Workers	632	666	12,240	18.38	17
18	Housekeepers	1,324	1,394	13,936	10.00	18
19	Laundry	1,324	1,394	11,860	8.51	19
20	Administrator	1,008	1,061	48,363	45.58	20
21	Assistant Administrator					21
22	Other Administrative	1,482	1,560	36,520	23.41	22
23	Office Manager					23
24	Clerical	316	333	3,994	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	31,200	15.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	257	270	3,380	12.52	31
32	Other Health Care TRANSPORT	751	790	9,485	12.01	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	46,812	49,276	\$ 870,771 *	\$ 17.67	34

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	46	\$ 2,300	1	35
36	Medical Director	monthly	3,667	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	824	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	25	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	6	489	15	46
47	Vision	4	90	15	47
48	Dental	32	800	15	48
49	TOTAL (lines 35 - 48)	89	\$ 8,195		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	36	\$ 2,789	10	50
51	Licensed Practical Nurses	0	0	10	51
52	Certified Nurse Assistants/Aides	172	6,935	10	52
53	TOTAL (lines 50 - 52)	208	\$ 9,724		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Jessica O'Neill	Administrator		\$ 30,449
Lemuel Pablo	Asst. Administrator		17,914
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,363
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
KPMG	audit fees		\$ 2,925
Polsinelli Shugart, PC	legal fees		922
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,847
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 17,773
Unemployment Compensation Insurance			5,332
FICA Taxes			66,614
Employee Health Insurance			49,142
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension			12,464
Dental			4,897
Life Insurance			451
Long Term Disability			306
TOTAL (agree to Schedule V, line 22, col.8)			\$ 156,979
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			2,079
Health Care Worker Background Check (Indicate # of checks performed _____)			
Patient Background Checks			
Dues/subscriptions			416
IHCA Dues			839
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 3,334
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$

*** Attach copy of IMRF notifications**

****See instructions.**

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 \$839
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,099 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. \$ 70,267
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? Yes,Sch.8 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
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>
Copier	Minolta	BizHub 250	1