

		FOR BHF USE					

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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>0045567</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Marklund Tommy 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>1S385 Wyatt Drive</u> <u>Geneva</u> <u>60134</u>																									
NumberCityZip 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>											
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	(Date) _____																								
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	(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>☒ VOLUNTARY,NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) 3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</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 _____	_____
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	☐ "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 Marklund Tommy Home

0045567 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	5,705	0	0	5,705	13
14	TOTALS	5,705			5,705	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.69%

D. How many bed-hold days during this year were paid by the Department? 135 (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 8/18/03

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

Marklund Tommy Home

0045567

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	1,617	3,885	33,228		33,228		33,228			1
2	Food Purchase		48,124		48,124		48,124		48,124			2
3	Housekeeping	13,936	6,196	17	20,149		20,149		20,149			3
4	Laundry	11,860	2,113		13,973		13,973		13,973			4
5	Heat and Other Utilities			28,820	28,820		28,820		28,820			5
6	Maintenance	12,240	5,508	13,317	31,065		31,065		31,065			6
7	Other (specify):* DISPOSAL			3,814	3,814		3,814		3,814			7
8	TOTAL General Services	65,762	63,558	49,853	179,173		179,173		179,173			8
	B. Health Care and Programs											
9	Medical Director			3,692	3,692		3,692		3,692			9
10	Nursing and Medical Records	636,934	32,823	14,174	683,931		683,931		683,931			10
10a	Therapy	37,137	1,242	33	38,412		38,412		38,412			10a
11	Activities	27,780	4,604		32,384		32,384		32,384			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/EX/PSY			2,727	2,727		2,727		2,727			15
16	TOTAL Health Care and Programs	714,662	38,718	38,838	792,218		792,218		792,218			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	19,308	5,575	65,396	(3,268)	62,128		62,128			21
22	Employee Benefits & Payroll Taxes			156,714	156,714		156,714		156,714			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,742	2,742		2,742	(2,742)	(0)			24
25	Other Admin. Staff Transportation			1,259	1,259		1,259	(1,259)	0			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	19,308	208,571	316,755	(3,268)	313,487	(10,104)	303,383			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	869,300	121,584	297,262	1,288,146	(3,268)	1,284,878	(10,104)	1,274,774			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			110,437	110,437		110,437	(7,866)	102,571			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					3,268	3,268		3,268			35
36	Other (specify):*											36
37	TOTAL Ownership			121,876	121,876	3,268	125,144	(19,305)	105,839			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			71,100	71,100		71,100		71,100			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			71,100	71,100		71,100		71,100			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	869,300	121,584	490,238	1,481,122		1,481,122	(29,409)	1,451,713			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	(21,185)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,409)		\$	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))	\$ (29,409)		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

Marklund Tommy Home

ID# 0045567

Report Period Beginning: 07/01/10

Ending: 06/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Seminars	\$ (2,742)	24	1
2	Travel & Sustenance	(1,259)	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	(21,185)		49

Summary A

06/30/11

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

[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

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

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

FACILITY IDPH LICENSE NUMBER 0045567

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

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: 8,315

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 Sayers Home16-Bed Facility8,315 Square Feet16 Person Capacity

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

Marklund Richard Home16-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	Patient Care	37,200	1999	\$ 258,800	1
2					2
3	TOTALS	37,200		\$ 258,800	3

Facility Name & ID Number Marklund Tommy Home

#

0045567

Report Period Beginning:

07/01/10

Ending:

06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264		\$ 459,477
5			2003	2003	62,119	6,212	10	6,212		46,589
6										
7										
8										
	Improvement Type**									
9	BI Electrical Upgrade		2003		3,222		5			3,222
10	BI Gutter Installation		2004		383		5			383
11	BI Emergency Battery Lights - Generator		2005		333	33	10	33		216
12	LI Sealcoating driveway and paths		2005		1,712		2			1,712
13	LI Grading and seeding of land parcel		2005		301		5			301
14	LI Bollard lighting		2005		1,300		5			1,300
15	LI Concrete slabs by dumpsters		2006		1,950	195	5	195		1,950
16	LI Custom exterior signage		2006		1,227		5			1,227
17	BI Wall carpeting		2006		5,484	548	5	548		5,484
18	BI Lightning Protection System		2008		3,100	620	5	620		2,170
19	BI Epoxy Flooring Installation		2008		5,420	1,084	5	1,084		3,794
20	BI Tile Installation Under Kitchen Cabinets		2008		771	154	5	154		540
21	LI Hot Rubber Crackfill Repair		2008		427		2			427
22	LI Sealcoating Driveway and Sidewalks		2008		1,525		2			1,525
23	LI Installation of 2 Bollard Lights		2009		637	127	5	127		319
24	BI Sprinkler System Repair		2009		2,038	407	5	407		1,019
25	BI Installation of Corain Baseboard and Oak Railing		2009		23,700	4,740	5	4,740		11,850
26	BI Oak Plywood Shelving		2009		1,045	209	5	209		523
27	LI Replacement of dumpster gate		2010		166	33	5	33		50
28	BI Door/Threshold Replacement		2010		3,623	725	5	725		1,087
29	BI Corian Baseboard Trim/Carpet		2010		12,850	2,570	5	2,570		3,855
30	LI Asphalt Repairs Noth Approach to NE Parking Lot		2011		1,217	122	5	122		122
31	LI Replacement Asphalt sidewalks W/concrete		2011		4,501	225	10	225		225
32	LI Replacement Asphalt sidewalks W/concrete		2011		4,667	233	10	233		233
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)		\$ 1,368,990	\$ 79,501		\$ 79,501	\$	\$ 549,599	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	\$103,926	\$16,263	\$16,263	\$		\$81,162	71
72	Current Year Purchases	12,730	1,108	1,108			1,108	72
73	Fully Depreciated Assets	39,671					39,671	73
74								74
75	TOTALS	\$156,327	\$17,371	\$17,371	\$		\$121,941	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 Fod El Dorado	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 Ford 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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,820,687	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$102,571	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$102,571	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)	\$699,563	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.

		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?
16. Rental Amount for movable equipment: \$ 3,268
- 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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 731,969	\$ 731,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 184,000)	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): client related accounts	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	2	
		Operating	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	compesation & 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)	\$ 28,906,412	\$ 28,906,412	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,278,647	\$ 33,278,647	48

*(See instructions.)

		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)	(140,690)	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	216,246	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 542,075	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)	\$ 28,906,412	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	\$ 1,307,693	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,307,693	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)	\$ 1,340,432	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	179,173	31
32	Health Care	792,218	32
33	General Administration	316,755	33
	B. Capital Expense		
34	Ownership	121,876	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	71,100	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,481,122	40
41	Income before Income Taxes (line 30 minus line 40)**	(140,690)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (140,690)	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	6,837	7,197	205,228	28.52	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	22,546	23,733	322,536	13.59	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	3,005	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	38,792	18.65	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)	46,476	48,923	\$ 869,300 *	\$ 17.77	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	3,692	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	33	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	13	1,084	15	46
47	Vision	2	45	15	47
48	Dental	31	775	15	48
49	TOTAL (lines 35 - 48)	93	\$ 8,753		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	92	\$ 6,109	10	50
51	Licensed Practical Nurses	16	847	10	51
52	Certified Nurse Assistants/Aides	216	7,218	10	52
53	TOTAL (lines 50 - 52)	324	\$ 14,174		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberMarklund Tommy Home

0045567

Report Period Beginning:07/01/10

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Ending:06/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica O'Neall	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	\$ 17,743	
Unemployment Compensation Insurance	5,323	
FICA Taxes	66,502	
Employee Health Insurance	49,059	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Pension	12,443	
Dental	4,889	
Life Insurance	450	
Long Term Disability	305	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 156,714

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. \$ 11,106 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. \$ 71,100
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 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