

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0045559

Facility Name: Marklund Van Der Molen Home

Address: 1 South 406 Wyatt Drive Geneva 60134
Number City Zip Code

County: Kane

Telephone Number: (630) 593-5500 Fax # (630) 593-5501

HFS ID Number:

Date of Initial License for Current Owners: 07/14/03

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Lynn Melvin Telephone Number: (630) 593-5485
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/11 to 06/30/12 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.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Gilbert W. Fonger
(Title) _____

Paid
Preparer

(Signed) President/ CEO _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number Marklund Van Der Molen Home# 0045559 Report Period Beginning: 07/01/11 Ending: 06/30/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	5,836			5,836	13
14	TOTALS	5,836			5,836	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 99.66%

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

20 (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?

yesG. 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 8/4/03

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

YES ☐

Date _____

NO ☒

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

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/12Fiscal Year: 06/30/12

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

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	31,599	1,562	3,381	36,542		36,542		36,542			1
2	Food Purchase		50,526		50,526		50,526		50,526			2
3	Housekeeping	16,016	6,801		22,817		22,817		22,817			3
4	Laundry	13,253	2,461	3,405	19,120		19,120		19,120			4
5	Heat and Other Utilities			26,876	26,876		26,876		26,876			5
6	Maintenance	12,240	5,172	21,372	38,785		38,785		38,785			6
7	Other (specify):* Disposal Service			3,588	3,588		3,588		3,588			7
8	TOTAL General Services	73,109	66,523	58,622	198,253		198,253		198,253			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	635,338	39,600	1,396	676,334		676,334		676,334			10
10a	Therapy	42,526	926	208	43,660		43,660		43,660			10a
11	Activities	29,305	3,288		32,593		32,593		32,593			11
12	Social Services	4,329			4,329		4,329		4,329			12
13	CNA Training											13
14	Program Transportation	9,641		16,330	25,970		25,970		25,970			14
15	Other (specify):* Vision, Dental,Pharmacy & Pysch consultants			1,943	1,943		1,943		1,943			15
16	TOTAL Health Care and Programs	721,138	43,814	23,876	788,828		788,828		788,828			16
	C. General Administration											
17	Administrative	26,976			26,976		26,976		26,976			17
18	Directors Fees											18
19	Professional Services			3,907	3,907		3,907		3,907			19
20	Dues, Fees, Subscriptions & Promotions			8,886	8,886		8,886	(3,745)	5,141			20
21	Clerical & General Office Expenses	24,233	20,814	9,780	54,827	(3,756)	51,071		51,071			21
22	Employee Benefits & Payroll Taxes			153,540	153,540		153,540		153,540			22
23	Inservice Training & Education											23
24	Travel and Seminar			923	923		923	(923)				24
25	Other Admin. Staff Transportation			9,235	9,235		9,235	(9,235)				25
26	Insurance-Prop.Liab.Malpractice			30,690	30,690		30,690		30,690			26
27	Other (specify):* fundraising/promotional			1,667	1,667		1,667	(1,667)				27
28	TOTAL General Administration	51,208	20,814	218,628	290,650	(3,756)	286,894	(15,570)	271,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	845,455	131,151	301,125	1,277,732	(3,756)	1,273,976	(15,570)	1,258,406			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			105,533	105,533		105,533	(6,598)	98,935			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,098	2,098		2,098	(2,098)	(0)			32
33	Real Estate Taxes			23	23		23	(23)				33
34	Rent-Facility & Grounds			8,323	8,323		8,323	(8,323)				34
35	Rent-Equipment & Vehicles					3,756	3,756		3,756			35
36	Other (specify):*											36
37	TOTAL Ownership			115,976	115,976	3,756	119,732	(17,042)	102,690			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			71,132	71,132		71,132		71,132			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			71,132	71,132		71,132		71,132			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	845,455	131,151	488,233	1,464,840		1,464,840	(32,612)	1,432,227			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,098)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,745)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,667)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,510)		\$	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (7,510)		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 Van Der Molen Home

Report Period Beginning: ID# 0045559

Ending: 07/01/11

06/30/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Seminars	\$ (923)	24	1
2	Travel & Sustenance	(9,235)	25	2
3	Depreciation	(6,598)	30	3
4	Real Estate Taxes	(23)	33	4
5	Rent	(8,323)	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	(25,102)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Van Der Molen Home # 0045559 Report Period Beginning: 07/01/11 Ending: 06/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,745)	0	0	0	0	0	0	0	0	0	0	(3,745)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(923)	0	0	0	0	0	0	0	0	0	0	(923)	24
25	Other Admin. Staff Transportation	(9,235)	0	0	0	0	0	0	0	0	0	0	(9,235)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	27
28	TOTAL General Administration	(15,570)	0	0	0	0	0	0	0	0	0	0	(15,570)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,570)	0	0	0	0	0	0	0	0	0	0	(15,570)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,598)	0	0	0	0	0	0	0	0	0	0	(6,598)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,098)	0	0	0	0	0	0	0	0	0	0	(2,098)	32
33	Real Estate Taxes	(23)	0	0	0	0	0	0	0	0	0	0	(23)	33
34	Rent-Facility & Grounds	(8,323)	0	0	0	0	0	0	0	0	0	0	(8,323)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,042)	0	0	0	0	0	0	0	0	0	0	(17,042)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(32,612)	0	0	0	0	0	0	0	0	0	0	(32,612)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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

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

X

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	12,890,465	12,890,465	\$ 114	\$	1,192,092	\$ 11	1
2	2	Food	Direct Cost Budget	12,890,465	12,890,465	508		1,192,092	47	2
3	3	Housekeeping	Direct Cost Budget	12,890,465	12,890,465	7,519		1,192,092	695	3
4	5	Utilities	Direct Cost Budget	12,890,465	12,890,465	56,535		1,192,092	5,228	4
5	6	Maintenance	Direct Cost Budget	12,890,465	12,890,465	26,304		1,192,092	2,433	5
6	7	Disposal	Direct Cost Budget	12,890,465	12,890,465	10,819		1,192,092	1,001	6
7	13	BNATP	Direct Cost Budget	12,890,465	12,890,465	0		1,192,092	0	7
8	14	Transportation	Direct Cost Budget	12,890,465	12,890,465	5,132		1,192,092	475	8
9	19	Professional Services	Direct Cost Budget	12,890,465	12,890,465	33,917		1,192,092	3,137	9
10	20	Fees,Subscriptions	Direct Cost Budget	12,890,465	12,890,465	47,695		1,192,092	4,411	10
11	21	Clerical/Office	Direct Cost Budget	12,890,465	12,890,465	249,973		1,192,092	23,117	11
12	22	Benefits	Direct Cost Budget	12,890,465	12,890,465	45,330		1,192,092	4,192	12
13	24	Travel & Seminar	Direct Cost Budget	12,890,465	12,890,465	3,879		1,192,092	359	13
14	25	Staff Transportation	Direct Cost Budget	12,890,465	12,890,465	9,487		1,192,092	877	14
15	26	Insurance	Direct Cost Budget	12,890,465	12,890,465	26,147		1,192,092	2,418	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 523,358	\$		\$ 48,401	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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Marklund Van Der Molen Home

COUNTY

Kane

FACILITY IDPH LICENSE NUMBER

0045559

CONTACT PERSON REGARDING THIS REPORT

Kudus Badmus

TELEPHONE

(630) 593-5487

FAX #:

(630) 593-5501

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 11-24-191-006	Residential - Tax exempt	\$ None	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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/Cedar

Frame Wood/Steel

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Marklund Hyde Center	Day Training	43,000 Square Feet	102 Person Capacity
Marklund Haverkamp Home	16-Bed Facility	8,315 Square Feet	16 Person Capacity
Marklund Sayers Home	16-Bed Facility	8,315 Square Feet	16 Person Capacity
Marklund Tommy Home	16-Bed Facility	8,315 Square Feet	16 Person Capacity
Marklund Mill Creek Home 3	16-Bed Facility	8,815 Square Feet	16 Person Capacity
Marklund Richard Home	16-Bed Facility	8,815 Square Feet	16 Person Capacity

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	37,200	1999	\$ 175,688	1
2					2
3	TOTALS	37,200		\$ 175,688	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		2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264		\$ 520,741
5			2003	2003	42,170	4,217	10	4,217		35,844
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		249
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		5			1,950
16	LI Custom exterior signage		2006		1,227		5			1,227
17	BI Mecho Shades		2008		2,118	424	5	424		1,906
18	BI Lightning Protection System		2008		3,100	620	5	620		2,790
19	BI Tile Installation Under Cabinets		2008		771	154	5	154		694
20	LI Hot Rubber Crackfill Repair		2008		427		2			427
21	LI Sealcoating Driveway/Sidewalks		2008		1,525		2			1,525
22	BI Epoxy Flooring Installation / Bathroom		2008		5,420	1,084	5	1,084		4,878
23	LI Installaton of 2 Bollard lights		2009		637	127	5	127		446
24	BI Oak Plywood Shelving		2009		1,045	209	5	209		732
25	LI Rreplacement of dumpster gate		2010		166	33	5	33		83
26	BI Replacment Baseboard Trim & wall Carpeting		2011		25,000	5,000	5	5,000		7,500
27	LI Asphalt Repairs North Approach to NE Lot		2011		1,217	243	5	243		365
28	LI Replace Asphalt Sidewalks W/ Concrete		2011		4,501	450	10	450		675
29	LI Replace Asphalt Sidewalks W/ Concrete		2011		4,667	467	10	467		700
30	BI Gutter Extension Over Patio		2012		423	42	5	42		42
31	LI Refurbishing of Exterior Signs		2012		1,664	166	5	166		166
32	LI Asphalt Repairs (Split w/Homes)		2012		163	16	5	16		16
33	LI Replacement of Posts - Generator		2012		483	48	5	48		48
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)		\$1,331,197	\$74,599		\$74,599	\$	\$589,924	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	\$111,619	\$14,765	\$14,765	\$		\$91,482	71
72	Current Year Purchases	32,483	3,259	3,259			3,259	72
73	Fully Depreciated Assets	45,116					45,116	73
74								74
75	TOTALS	\$189,218	\$18,024	\$18,024	\$		\$139,857	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	2006 Ford Eldorado	2007	\$48,480	\$4,848	\$4,848	\$	5	\$48,480	76
77	Snow Plow Truck	2012 Ford F-350	2012	7,517	752	752		5	752	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	3,206	79
80	TOTALS			\$62,393	\$6,312	\$6,312	\$		\$55,272	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)	\$1,758,49681
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$98,93582
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$98,93583**
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)	\$785,05385

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: \$ 3,756
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 503,870	\$ 503,870	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>196,500</u>)	4,547,011	4,547,011	3
4	Supply Inventory (priced at _____)	58,147	58,147	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	116,686	116,686	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	635,356	635,356	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,861,070	\$ 5,861,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,444,979	6,444,979	13
14	Buildings, at Historical Cost	22,651,049	22,651,049	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,736,088	4,736,088	16
17	Accumulated Depreciation (book methods)	(16,757,130)	(16,757,130)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,921,984	6,921,984	21
22	Other Long-Term Assets (specify): _____	4,304,940	4,304,940	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,301,910	\$ 28,301,910	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,162,980	\$ 34,162,980	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 356,675	\$ 356,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	680,000	680,000	29
30	Accrued Salaries Payable	146,133	146,133	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,422	12,422	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	<u>compesation & related payables</u>	888,183	888,183	36
37	<u>misc. other</u>	2,630,041	2,630,041	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,713,454	\$ 4,713,454	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)	\$ 4,713,454	\$ 4,713,454	46
47	TOTAL EQUITY(page 18, line 24)	\$ 29,449,526	\$ 29,449,526	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,162,980	\$ 34,162,980	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 28,906,412	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 28,906,412	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(143,680)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,388,390	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	(580,004)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 664,706	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- exp.	(121,592)	18
19	Transfers out of Restricted Funds into Operations-capital	(274,689)	19
20	Transfers into Operations from Restricted Funds	274,689	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (121,592)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 29,449,526	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Van Der Molen Home

0045559

Report Period Beginning: 07/01/11

Ending: 06/30/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,298,627	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,298,627	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	104	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)	\$ 104	23
	D. Non-Operating Revenue		
24	Contributions	22,429	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,429	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)	\$ 1,321,160	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	198,253	31
32	Health Care	788,828	32
33	General Administration	290,650	33
	B. Capital Expense		
34	Ownership	115,976	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	71,132	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,464,840	40
41	Income before Income Taxes (line 30 minus line 40)**	(143,680)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (143,680)	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,204,567	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security</u>	94,060	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,298,627	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	\$ 11,913	\$ 40.91	1
2	Assistant Director of Nursing	652	686	20,173	29.39	2
3	Registered Nurses	6,699	7,051	202,965	28.78	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	22,941	24,149	353,435	14.64	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,146	1,206	38,245	31.70	7
8	Rehab/Therapy Aides	277	291	4,281	14.70	8
9	Activity Director	0	0	0		9
10	Activity Assistants	2,035	2,142	29,305	13.68	10
11	Social Service Workers	257	270	4,329	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	652	686	19,247	28.04	13
14	Head Cook	336	354	5,710	16.15	14
15	Cook Helpers/Assistants	336	354	3,460	9.79	15
16	Dishwashers	336	354	3,182	9.00	16
17	Maintenance Workers	632	666	12,240	18.39	17
18	Housekeepers	1,522	1,602	16,016	10.00	18
19	Laundry	1,324	1,394	13,253	9.51	19
20	Administrator	336	354	16,442	46.50	20
21	Assistant Administrator	316	333	10,533	31.65	21
22	Other Administrative	329	347	17,663	50.97	22
23	Office Manager	0	0	0		23
24	Clerical	421	444	6,570	14.81	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,976	2,080	43,472	20.90	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	257	270	3,380	12.50	31
32	Other Health Care(specify)	741	780	9,641	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	43,798	46,103	\$ 845,455 *	\$ 18.34	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	44	\$ 2,223	1	35
36	Medical Director	monthly	4,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	718	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	57	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	5	425	15	46
47	Vision	0	0	15	47
48	Dental	32	800	15	48
49	TOTAL (lines 35 - 48)	84	\$ 8,222		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 360	10	50
51	Licensed Practical Nurses	4	156	10	51
52	Certified Nurse Assistants/Aides	38	880	10	52
53	TOTAL (lines 50 - 52)	50	\$ 1,396		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberMarklund Van Der Molen Home# 0045559Report Period Beginning: 07/01/11Ending: 06/30/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica O'Neill	Administator		\$ 16,442
Lemuel Pablo	Asst. Administrator		10,533
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 26,976

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	\$ 3,137
Polsinelli Shugart, PC	legal fees	771
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 3,907

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 17,219	
Unemployment Compensation Insurance	5,341	
FICA Taxes	64,677	
Employee Health Insurance	49,371	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Pension	11,256	
Dental	4,814	
Life Insurance	438	
Long Term Disability	423	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 153,540

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	3,150	
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Dues/subscriptions	1,152	
IHCA Dues	839	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,141

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.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

\$

13,569

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.

\$

71,132

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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

Yes

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

0
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

KPMG
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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 283	1

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