

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0045567

Facility Name: Marklund Tommy Home

Address: 1 South 385 Wyatt Dr Geneva 60134
Number City Zip Code

County: Kane

Telephone Number: (630) 593-5493 Fax # (630) 397-5037

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 07/01/15 to 06/30/16 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) CEO/President

Paid
Preparer

(Signed) _____ (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 Tommy Home

0045567 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,550			5,550	13
14	TOTALS	5,550			5,550	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.77%

D. How many bed-hold days during this year were paid by the Department? 39 (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 08/18/03

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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/16 Fiscal Year: 06/30/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Marklund Tommy Home** # **0045567** Report Period Beginning: **07/01/15** Ending: **06/30/16**
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	20,176	1,283	2,914	24,373		24,373		24,373			1
2	Food Purchase		38,391		38,391		38,391		38,391			2
3	Housekeeping	15,469	5,405	1,757	22,631		22,631		22,631			3
4	Laundry	13,588	2,898		16,486		16,486		16,486			4
5	Heat and Other Utilities			26,050	26,050		26,050		26,050			5
6	Maintenance	19,522	4,850	12,691	37,063		37,063		37,063			6
7	Other (specify):* Disposal Services			1,734	1,734		1,734		1,734			7
8	TOTAL General Services	68,755	52,828	45,145	166,728		166,728		166,728			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	645,780	38,840	37,248	721,868		721,868		721,868			10
10a	Therapy	77,341	1,296	2,429	81,066		81,066		81,066			10a
11	Activities	35,447	4,876		40,323		40,323		40,323			11
12	Social Services	4,329			4,329		4,329		4,329			12
13	CNA Training											13
14	Program Transportation	6,427		14,865	21,292		21,292		21,292			14
15	Other (specify):* Vision, Dental, Pharmacy & Pysch consultants			2,839	2,839		2,839		2,839			15
16	TOTAL Health Care and Programs	769,324	45,012	61,381	875,717		875,717		875,717			16
	C. General Administration											
17	Administrative	26,667			26,667		26,667		26,667			17
18	Directors Fees											18
19	Professional Services			6,033	6,033		6,033		6,033			19
20	Dues, Fees, Subscriptions & Promotions			9,076	9,076		9,076	(2,924)	6,152			20
21	Clerical & General Office Expenses	16,594	24,162	5,653	46,409	(4,198)	42,212		42,212			21
22	Employee Benefits & Payroll Taxes			197,644	197,644		197,644		197,644			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,449	2,449		2,449	(2,449)	(0)			24
25	Other Admin. Staff Transportation			4,059	4,059		4,059	(4,059)	0			25
26	Insurance-Prop.Liab.Malpractice			23,847	23,847		23,847		23,847			26
27	Other (specify):* fund-raising/promotional			1,667	1,667		1,667	(1,667)	(0)			27
28	TOTAL General Administration	43,260	24,162	250,428	317,851	(4,198)	313,653	(11,099)	302,554			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	881,339	122,003	356,955	1,360,296	(4,198)	1,356,098	(11,099)	1,344,999			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			101,552	101,552		101,552	(8,701)	92,851			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			761	761		761	(761)	(0)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			8,718	8,718		8,718	(8,718)	0			34
35	Rent-Equipment & Vehicles					4,198	4,198		4,198			35
36	Other (specify):*											36
37	TOTAL Ownership			111,031	111,031	4,198	115,229	(18,180)	97,049			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,961	76,961		76,961		76,961			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			76,961	76,961		76,961		76,961			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	881,339	122,003	544,947	1,548,288		1,548,288	(29,279)	1,519,009			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	(761)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,924)	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	(23,927)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,279)		\$	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))	\$ (29,279)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Seminars	\$ (2,449)	24	1
2	Travel & Sustenance	(4,059)	25	2
3	Depreciation	(8,701)	30	3
4	Rent	(8,718)	34	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(23,927)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(2,924)	0	0	0	0	0	0	0	0	0	0	(2,924)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,449)	0	0	0	0	0	0	0	0	0	0	(2,449)	24
25	Other Admin. Staff Transportation	(4,059)	0	0	0	0	0	0	0	0	0	0	(4,059)	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	(11,099)	0	0	0	0	0	0	0	0	0	0	(11,099)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(11,099)	0	0	0	0	0	0	0	0	0	0	(11,099)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(8,701)	0	0	0	0	0	0	0	0	0	0	(8,701)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(761)	0	0	0	0	0	0	0	0	0	0	(761)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(8,718)	0	0	0	0	0	0	0	0	0	0	(8,718)	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	(18,180)	0	0	0	0	0	0	0	0	0	0	(18,180)	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)	(29,279)	0	0	0	0	0	0	0	0	0	0	(29,279)	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

X 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: 07/01/15 Ending: 06/30/16

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	15,991,092	15,991,092	\$ 8	\$	1,366,796	\$ 1	1
2	2	Food	Direct Cost Budget	15,991,092	15,991,092	1,033		1,366,796	88	2
3	3	Housekeeping	Direct Cost Budget	15,991,092	15,991,092	5,856		1,366,796	501	3
4	5	Utilities	Direct Cost Budget	15,991,092	15,991,092	52,741		1,366,796	4,508	4
5	6	Maintenance	Direct Cost Budget	15,991,092	15,991,092	16,445		1,366,796	1,406	5
6	7	Disposal	Direct Cost Budget	15,991,092	15,991,092	3,476		1,366,796	297	6
7	13	BNATP	Direct Cost Budget	15,991,092	15,991,092	0		1,366,796	0	7
8	14	Transportation	Direct Cost Budget	15,991,092	15,991,092	5,672		1,366,796	485	8
9	19	Professional Services	Direct Cost Budget	15,991,092	15,991,092	58,590		1,366,796	5,008	9
10	20	Fees,Subscription	Direct Cost Budget	15,991,092	15,991,092	60,531		1,366,796	5,174	10
11	21	Clerical/Office	Direct Cost Budget	15,991,092	15,991,092	202,404		1,366,796	17,300	11
12	22	Benefits	Direct Cost Budget	15,991,092	15,991,092	66,810		1,366,796	5,710	12
13	24	Travel & Seminar	Direct Cost Budget	15,991,092	15,991,092	11,757		1,366,796	1,005	13
14	25	Staff Transportation	Direct Cost Budget	15,991,092	15,991,092	7,592		1,366,796	649	14
15	26	Insurance	Direct Cost Budget	15,991,092	15,991,092	20,945		1,366,796	1,790	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 513,861	\$		\$ 43,922	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2016 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:		2011		8		
		2012		9		
		2013		10		
		2014		11		
		2015		12		
				FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015	\$		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 2015 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 2015.

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

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.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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).

Markllund Hyde Center Day Training 43,000 SF 112 person capcaity

Marklund Haverkamp Home 16 bed faci;ity 8315 sf 16 person capacity

Marklund Van Der Molen Home 16 bed facility 8315 sf 16 perspn capcity

Marklund Sayers Home 16 bed facility 8315 sf 16 person capacity

Marklund Dreher Home 16 bed facility 8815 sf 16 person capacity

Marklund Richard Home 16 Bed facility 8815 sf 16 person capacity

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient care	32,700	1999	\$ 258,800	1
2					2
3	TOTALS	32,700		\$ 258,800	3

Facility Name & ID Number Marklund Tommy Home

#

0045567

Report Period Beginning:

07/01/15

Ending:

06/30/16

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		\$ 765,796
5			2003	2003	62,119		10			62,119
6										
7										
8										
	Improvement Type**									
9	BI electrical upgrade			2003	3,222		5			3,222
10	BI gutter installation			2004	383		5			383
11	emerency battery lighta - gementer			2005	333		10			333
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 wall carpetng			2006	5,484		5			5,484
18	BI lightniong protection system			2008	3,100		5			3,100
19	BI expoxy flooring installation			2008	5,420		5			5,420
20	BI tile installation under kitchen cabinets			2008	771		5			771
21	LI Hot rubber crackfill repair			2008	427		2			427
22	LI sealcoating driveway and sidewalks			2008	1,525		2			1,525
23	LI installaton of 2 bollard lights			2009	637		5			637
24	BI sprinkler system repair			2009	2,038		5			2,038
25	BI installation of corian baseboard and oak railing			2009	23,700		5			23,700
26	BI oak plywood shelving			2009	1,045		5			1,045
27	LI replacement of dumpster gate			2010	166		5			166
28	BI door/threshold replacement			2010	3,623		5			3,623
29	BI corian baseboard trim /carpet			2010	12,850		5			12,850
30	LI asphalt repairs north to NE parking lot			2011	1,217	122	5	122		1,217
31	LI replacment of asphalt sidewalks w/concrete			2011	4,501	450	10	450		2,475
32	LI replacement of asphalt sidewalks w/concrete			2011	4,667	467	10	467		2,567
33	BI gutter extension over patio			2012	423	85	5	85		380
34	LI refurbishing of exterior signs			2012	1,664	333	5	333		1,498
35	LI asphalt repairs (split all homes)			2012	163	33	5	33		146
36	replacement of floor covering			2013	38,189	7,638	5	7,638		26,732

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Tommy Home

0045567

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LI wheelchari glider w/concrete pad (split all homes)	2013	\$ 1,562	\$ 312	5	\$ 312	\$	\$ 1,093	37
38	LI concrete replacement of asphalt sidewalk	2014	2,883	283	10	283		708	38
39	BI window and sah replacement	2015	13,042	2,608	5	2,608		3,913	39
40	LI phase III replace asphalt w/concrete	2015	4,017	402	10	402		603	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)		\$ 1,430,932	\$ 73,996		\$ 73,996	\$	\$ 940,460	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	\$73,613	\$14,316	\$14,316	\$		\$50,472	71
72	Current Year Purchases	6,518	924	924			924	72
73	Fully Depreciated Assets	142,623	142,623		(142,623)		142,623	73
74								74
75	TOTALS	\$222,754	\$157,862	\$15,239	\$(142,623)		\$194,019	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Patient Transport	2008 Ford El Dorado (1/2)	2008	\$24,925	\$	\$	\$	5	\$24,925
77	Snow Plow Truck	2012 Ford F-350 (1/6)	2012	7,517	1,503	1,503		5	6,765
78	Maintenance	2013 Fgord F-250 truck (1/6)	2013	4,586	917	917		5	3,210
79	Patient Transport	2014 Ford Ambulette (1/6)	2015	5,978	1,196	1,196		5	1,794
80	TOTALS			\$43,006	\$3,616	\$3,616	\$		\$36,694

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)			\$1,955,492	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$235,473	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$92,851	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$(142,623)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$1,171,172	

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		\$	\$	
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:
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: \$4,198
- 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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs			0				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	\$ 842,189	\$ 842,189	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 246,500)	2,639,956	2,639,956	3
4	Supply Inventory (priced at)	81,185	81,185	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	180,974	180,974	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): client related accounts	667,714	667,714	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,412,018	\$ 4,412,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,865,917	6,865,917	13
14	Buildings, at Historical Cost	25,506,038	25,506,038	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,270,044	6,270,044	16
17	Accumulated Depreciation (book methods)	(21,543,200)	(21,543,200)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,916,012	6,916,012	21
22	Other Long-Term Assets (specify):	5,393,729	5,393,729	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,408,540	\$ 29,408,540	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,820,558	\$ 33,820,558	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 262,582	\$ 262,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,358	312,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,052	24,052	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	compensation & related payables	(184,258)	(184,258)	36
37	misc. other	1,480,580	1,480,580	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,895,314	\$ 1,895,314	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)	\$ 1,895,314	\$ 1,895,314	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,925,244	\$ 31,925,244	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,820,558	\$ 33,820,558	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 32,962,877	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,962,877	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(157,074)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	839,788	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	(2,657,325)	15
16	Other (describe) loss on disposal of building & equipment	8,192	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,966,419)	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- exp.	928,786	18
19	Transfers out of Restricted Funds into Operations-capital	290,306	19
20	Transfers into Operations from Restricted Funds	(290,306)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 928,786	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,925,244	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Tommy Home

0045567

Report Period Beginning: 07/01/15

Ending: 06/30/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,280,183	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,280,183	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		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 1,280,183	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	166,728	31
32	Health Care	875,717	32
33	General Administration	317,851	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	76,961	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,437,257	40
41	Income before Income Taxes (line 30 minus line 40)**	(157,074)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (157,074)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,201,491	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	78,692	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,280,183	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	\$ 10,501	\$ 36.06	1
2	Assistant Director of Nursing	988	1,040	31,782	30.56	2
3	Registered Nurses	6,639	6,989	174,720	25.00	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	25,648	26,998	394,447	14.61	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	2,035	2,142	73,142	34.14	7
8	Rehab/Therapy Aides	277	291	4,199	14.42	8
9	Activity Director	316	333	6,992	21.01	9
10	Activity Assistants	1,976	2,080	28,454	13.68	10
11	Social Service Workers	257	270	4,329	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	336	354	7,822	22.12	13
14	Head Cook	336	354	5,711	16.15	14
15	Cook Helpers/Assistants	336	354	3,462	9.79	15
16	Dishwashers	336	354	3,182	9.00	16
17	Maintenance Workers	632	666	19,522	29.33	17
18	Housekeepers	1,324	1,394	15,469	11.10	18
19	Laundry	1,324	1,394	13,588	9.75	19
20	Administrator	316	333	15,475	46.50	20
21	Assistant Administrator	336	354	11,191	31.65	21
22	Other Administrative	165	173	9,802	56.57	22
23	Office Manager	0	0	0		23
24	Clerical	415	437	6,792	15.55	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)	1,482	1,560	30,545	19.58	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	277	291	3,786	13.00	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	46,522	48,970	\$ 881,339 *	\$ 18.00	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	\$ 2,217	1	35
36	Medical Director	monthly	4,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,004	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	varies	2,429	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	9	723	15	46
47	Vision	visit	338	15	47
48	Dental	vist	775	15	48
49	TOTAL (lines 35 - 48)	53	\$ 11,485		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	237	\$ 12,064	10	50
51	Licensed Practical Nurses	173	6,983	10	51
52	Certified Nurse Assistants/Aides	479	18,200	10	52
53	TOTAL (lines 50 - 52)	888	\$ 37,248		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Marklund Tommy Home

0045567

Report Period Beginning: 07/01/15

Page 21

Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachelle Jewison	Administrator		\$ 18,333
Antonio Quinones	Asst. Admin.		8,333
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 26,667

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	\$ 5,007
Robin R Kelleher	legal fees	1,026
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 6,033

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 25,050	
Unemployment Compensation Insurance	6,868	
FICA Taxes	67,422	
Employee Health Insurance	74,835	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Pension	15,299	
Dental	6,586	
Life Insurance	1,512	
Long Term Disability	72	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 197,644

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	4,768	
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Dues/subscriptions	472	
IHCA Dues	912	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,152

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

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 , \$912
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,904 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,961
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. _____
Attach invoices and a summary of services for all architect and appraisal fees

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>	<u>Location</u>
Copier	Minolta	BizHub 224E	1	MTH