

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0045575</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Marklund Sayers Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2019</u> to <u>06/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1 South 383 Wyatt Dr</u> <u>Geneva</u> <u>60134</u> Number City Zip Code																																																	
County: <u>Kane</u>																																																	
Telephone Number: <u>(630) 593-5496</u> Fax # <u>(630) 397-5038</u>																																																	
HFS ID Number: _____																																																	
Date of Initial License for Current Owners: <u>08/25/03</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Gilbert W. Fonger</u></td></tr><tr><td>(Title) <u>Presidnet/CEO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Gilbert W. Fonger</u>	(Title) <u>Presidnet/CEO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																																				
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	(Telephone) <u>()</u> Fax # <u>()</u>																																																
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code <u>501c3</u></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td></td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501c3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.		_____			☐	Limited Liability Co.		_____			☐	Trust		_____			☐	Other		_____
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		☐	Limited Liability Co.		_____																																												
		☐	Trust		_____																																												
		☐	Other		_____																																												
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																															
Name: <u>Lynn Melvin</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																															
Telephone Number: <u>(630) 593 5485</u>		201 S. Grand Avenue East																																															
Email Address: _____		Springfield, IL 62763-0001																																															
		Phone # (217) 782-1630																																															

Facility Name & ID Number Marklund Sayers Home

0045575 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	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	5,467			5,467	13
14	TOTALS	5,467			5,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.36%

D. How many bed reserve days during this year were paid by the Department? 4 (Do not include bed reserve days in Section B.)

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

N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 08/25/03

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

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

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	20,007	1,427	2,401	23,835		23,835		23,835			1
2	Food Purchase		43,934		43,934		43,934		43,934			2
3	Housekeeping	53,866	5,209	5,882	64,957		64,957		64,957			3
4	Laundry	19,796	3,004		22,800		22,800		22,800			4
5	Heat and Other Utilities			20,628	20,628		20,628		20,628			5
6	Maintenance	28,258	4,952	13,054	46,264		46,264		46,264			6
7	Other (specify):* Disposal Services			1,753	1,753		1,753		1,753			7
8	TOTAL General Services	121,927	58,526	43,718	224,171		224,171		224,171			8
	B. Health Care and Programs											
9	Medical Director			3,667	3,667		3,667		3,667			9
10	Nursing and Medical Records	769,751	42,004	25,742	837,497		837,497		837,497			10
10a	Therapy	114,379	1,057	78	115,514		115,514		115,514			10a
11	Activities	8,736	3,331		12,067		12,067		12,067			11
12	Social Services	5,005			5,005		5,005		5,005			12
13	CNA Training		243		243		243		243			13
14	Program Transportation	2,808		3,763	6,571		6,571		6,571			14
15	Other (specify):* Vision,Dental,Pharmacy & Pysch Consultants			3,697	3,697		3,697		3,697			15
16	TOTAL Health Care and Programs	900,679	46,635	36,947	984,261		984,261		984,261			16
	C. General Administration											
17	Administrative	25,611			25,611		25,611		25,611			17
18	Directors Fees											18
19	Professional Services			9,024	9,024		9,024	(3,427)	5,597			19
20	Dues, Fees, Subscriptions & Promotions			8,824	8,824		8,824	(2,548)	6,276			20
21	Clerical & General Office Expenses	42,254	27,000	9,519	78,773	(4,135)	74,638		74,638			21
22	Employee Benefits & Payroll Taxes			294,156	294,156		294,156		294,156			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,658	1,658		1,658	(1,151)	507			24
25	Other Admin. Staff Transportation			4,274	4,274		4,274	(4,780)	(506)			25
26	Insurance-Prop.Liab.Malpractice			20,274	20,274		20,274		20,274			26
27	Other (specify):* Bad Debt			1,623	1,623		1,623	(1,623)				27
28	TOTAL General Administration	67,865	27,000	349,352	444,217	(4,135)	440,082	(13,529)	426,553			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,090,471	132,161	430,017	1,652,649	(4,135)	1,648,514	(13,529)	1,634,985			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			90,570	90,570		90,570	(4,304)	86,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			971	971		971	(971)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					4,135	4,135		4,135			35
36	Other (specify):*											36
37	TOTAL Ownership			91,541	91,541	4,135	95,676	(5,275)	90,401			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			85,088	85,088		85,088		85,088			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			85,088	85,088		85,088		85,088			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,090,471	132,161	606,646	1,829,278		1,829,278	(18,804)	1,810,474			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	(971)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(450)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,427)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,623)	27		24
25	Fund Raising, Advertising and Promotional	(2,098)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,235)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,804)		\$	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))	\$ (18,804)		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		Amount	Sch. V Line Reference	
1	Seminars	\$ (1,151)	24	1
2	Travel & Sustenance	(4,780)	25	2
3	Depreciation	(4,304)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	(10,235)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Sayers Home# 0045575

Report Period Beginning:

07/01/2019

Ending:

06/30/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	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	(3,427)	0	0	0	0	0	0	0	0	0	0	(3,427)	19
20	Fees, Subscriptions & Promotions	(2,548)	0	0	0	0	0	0	0	0	0	0	(2,548)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,151)	0	0	0	0	0	0	0	0	0	0	(1,151)	24
25	Other Admin. Staff Transportation	(4,780)	0	0	0	0	0	0	0	0	0	0	(4,780)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,623)	0	0	0	0	0	0	0	0	0	0	(1,623)	27
28	TOTAL General Administration	(13,529)	0	0	0	0	0	0	0	0	0	0	(13,529)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,529)	0	0	0	0	0	0	0	0	0	0	(13,529)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(4,304)	0	0	0	0	0	0	0	0	0	0	(4,304)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(971)	0	0	0	0	0	0	0	0	0	0	(971)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,275)	0	0	0	0	0	0	0	0	0	0	(5,275)	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)	(18,804)	0	0	0	0	0	0	0	0	0	0	(18,804)	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		n/a	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	n/a							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Marklund Sayers Home# 0045575 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Sayers Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045575

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 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.	Residential - Tax exempt	\$	\$
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 sf 112 person capacity

Marklund Haverkamp Home 16 bed facility 8315 sf 16 person capacity

Marklund Van Der Molen Home 16 bed facility 8315 sf 16 person capacity

Marklund Tommy Home 16 bed facility 8315 sf 16 person capacity

Marklund 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	67,518	2003	\$ 318,871	1
2					2
3	TOTALS	67,518		\$ 318,871	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	\$	\$ 1,010,850
5										
6										
7										
8										
	Improvement Type**									
9	LI COST ALLOCATION LAND IMPROVMTS			2003	76,537		10			76,537
10	BI INSTALLATION OF MAGNETIC DOOR			2003	2,799		5			2,799
11	BI INSTALLATION OF INCANDESCENT			2003	400		5			400
12	BI Gutter installation-patio			2004	383		5			383
13	LI Grading/Seeding Land Parcel			2004	301		5			301
14	LI Sealcoat Driveway & Paths			2004	1,712		2			1,712
15	BI Bollard Lighting			2004	1,300		5			1,300
16	LI Emerg Battery Lights-Generator			2005	333		10			333
17	LI Custom Exterior Signage			2005	1,227		5			1,227
18	LI CONCRETE SLABS BY DUMPSTERS-4			2006	1,950		5			1,950
19	BI Painting of Sayers home			2007	4,683		5			4,683
20	BI TILE INSTALLATION UNDER			2007	771		5			771
21	LI HOT RUBBER CRACKFILL REPAIR			2008	427		2			427
22	LI SEALCOATING DRIVEWAY/SIDEWALKS			2008	1,525		2			1,525
23	BI LIGHTNING PROTECTION SYSTEM			2008	3,100		5			3,100
24	LI INSTALLATION OF 2 BOLLARD LGHT			2008	637		5			637
25	BI Oak Plywood Shelving (4)/			2008	1,045		5			1,045
26	BI Epoxy Bathroom Floors			2009	5,858		5			5,858
27	LI REPLACEMNT OF DUMPSTER GATE			2010	166		5			166
28	BI DOOR/THRESHOLD REPLACEMENT			2010	3,623		5			3,623
29	LI REPLACE ASPHALT SIDEWALKS WITH			2010	4,667	467	10	467		4,433
30	BI Replacement of Baseboard Trim			2011	25,000		5			25,000
31	LI Asphalt Repairs-North Approach			2011	1,217		5			1,217
32	LI Replacement-Asphalt Sidewalks			2011	4,501	450	10	450		4,276
33	LI Asphalt Repairs near Ballfield			2011	163		5			163
34	BI Gutter Extension over Patio			2011	423		5			423
35	LI REFURBISHING OF EXTERIOR SIGNS			2012	1,664		5			1,664
36	LI WheelChair Glider W/ Concrete			2012	1,562		5			1,562

*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 Sayers Home

0045575

Report Period Beginning:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BI Comfort Pro Condenser	2012	\$ 3,300	\$	5	\$	\$	\$ 3,300	37
38	LI CONCRETE REPLACEMENT OF	2013	2,833	283	10	283		1,842	38
39	BI FLOOR CARPET REPLACEMENT	2014	46,500	4,650	5	4,650		46,500	39
40	LI PHASE III-REPLACE CONCRETE W/	2014	4,017	402	10	402		2,209	40
41	BI Lamp flourescent drum Fixtures	2016	822	78	5	78		394	41
42	BI Data Line Install 10 line 5dp	2016	78	8	10	8		27	42
43	BI Electric Outlet Orient Room &	2016	169	8	20	8		30	43
44	BI CARPETING-NEW ORIENTATION ROOM	2016	288	58	5	58		201	44
45	LI Sink Hole Rpr Baseball Fld	2017	417	35	12	35		122	45
46	LI Outdoor Signage New Logo	2017	1,697	141	12	141		354	46
47	BI LED Fixture Replc, Recep Reloc	2017	1,150	115	10	115		288	47
48	LI Sink Hole Repair Baseball Fld	2017	983	82	12	82		205	48
49	LI Grind and Repavement	2017	712	47	15	47		119	49
50	BI Paintng Common Areas Main Enrt	2018	4,170	834	5	834		2,085	50
51	LI Sealcoating, Crackfil, Strip	2018	1,482	370	2	370		1,482	51
52	LI Replace Fence Posts Spt Evenly	2019	283	57	5	57		85	52
53	BI Replacement Door-Bathing Room	2019	1,557	156	10	156		234	53
54	BI Inerior Painting Bedrooms	2020	4,835	484	5	484		484	54
55	BI Window Blind Replacement	2020	318	32	5	32		32	55
56	BI Fire Alarm Panel	2020	1,583	79	10	79		79	56
57	BI Repair 4" Kitchen Floor Pipe Break in Concrete split	2020	2,360	118	10	118		118	57
58	BI Washing Machine Water Line Repair split 6 homes	2020	208	21	5	21		21	58
59	BI Panic Button Ssytem split all sites	2020	801	80	5	80		80	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)		\$ 1,453,810	\$ 70,319		\$ 70,319	\$	\$ 1,218,656	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	\$37,991	\$6,252	\$6,252	\$	5	\$17,282	71
72	Current Year Purchases	15,552	1,496	1,496		5	1,496	72
73	Fully Depreciated Assets	109,697	1,603	1,603		5	109,697	73
74								74
75	TOTALS	\$163,240	\$9,351	\$9,351	\$		\$128,475	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Maintenance	2013 Ford F250 Pickup 1/6	2013	\$4,586	\$	\$	\$	5	\$4,586
77	Patient Transport	2014 Ford Ambulette Van 1/6	2014	5,978	598	598		5	5,978
78	Patient Transport	2016 El Dorado Bus 1/3	2016	19,553	3,911	3,911		5	17,598
79	Patient Transport	2017 El Dorado Bus 1/6	2018	10,435	2,087	2,087		5	5,217
80	TOTALS			\$40,552	\$6,596	\$6,596	\$		\$33,379

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)			\$1,976,473	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$86,266	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$86,266	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$1,380,510	

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:n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$4,135Description: 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

* 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)	\$			

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	

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

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

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

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

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

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

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

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

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

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 39,797,188	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 39,797,188	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(205,302)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	872,412	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	4,010,318	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,677,428	17
	B. Transfers (Itemize):		
18	transfers out in to operations-expenses	46,338	18
19	transfers out in to operations-capial	2,872,497	19
20	transfers out in to operations-capial	(2,872,497)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 46,338	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 44,520,954	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Sayers Home

0045575

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,560,981	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,560,981	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	9,460	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)	\$ 9,460	23
	D. Non-Operating Revenue		
24	Contributions	53,535	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,535	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)	\$ 1,623,976	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	224,171	31
32	Health Care	984,261	32
33	General Administration	444,217	33
	B. Capital Expense		
34	Ownership	91,541	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	85,088	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,829,278	40
41	Income before Income Taxes (line 30 minus line 40)**	(205,302)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (205,302)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,314,593	44
45	Private Pay - Net Inpatient Revenue	101,642	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	144,746	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,560,981	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	276	291	\$ 12,600	\$ 43.30	1
2	Assistant Director of Nursing	1,708	1,798	60,987	33.92	2
3	Registered Nurses	5,421	5,706	172,621	30.25	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	24,045	25,310	461,913	18.25	5
6	CNA Trainees					6
7	Licensed Therapist	1,680	1,768	74,521	42.15	7
8	Rehab/Therapy Aides	2,075	2,184	39,858	18.25	8
9	Activity Director	296	312	8,736	28.00	9
10	Activity Assistants					10
11	Social Service Workers	164	173	5,005	28.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	336	354	8,168	23.07	14
15	Cook Helpers/Assistants	385	405	6,888	17.01	15
16	Dishwashers	336	354	4,950	13.98	16
17	Maintenance Workers	915	963	28,258	29.34	17
18	Housekeepers	3,529	3,715	53,866	14.50	18
19	Laundry	1,221	1,285	19,796	15.41	19
20	Administrator	296	312	17,325	55.53	20
21	Assistant Administrator	296	312	8,287	26.56	21
22	Other Administrative	99	104	13,584	130.62	22
23	Office Manager					23
24	Clerical	1,152	1,213	28,669	23.63	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	57,013	27.41	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	247	260	4,618	17.76	31
32	Other Health Care(specify)	198	208	2,808	13.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	46,651	49,107	\$ 1,090,471 *	\$ 22.21	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	41	\$ 2,025	1	35
36	Medical Director	monthly	3,667	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	1,573	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	78	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	15	1,281	15	46
47	Vision	visit	293	15	47
48	Dental	visit	551	15	48
49	TOTAL (lines 35 - 48)	57	\$ 9,467		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	29	\$ 1,338	10	50
51	Licensed Practical Nurses	44	2,000	10	51
52	Certified Nurse Assistants/Aides	898	22,404	10	52
53	TOTAL (lines 50 - 52)	970	\$ 25,742		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. Illinois Healthcare Association , \$953
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,719 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. \$ 85,088
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? n/a Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes
Attach invoices and a summary of services for all architect and appraisal fees.

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

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