

		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: 0054445

Facility Name: Marklund Wasmond Center

Address: 1435 Summit StreetElgin60120

NumberCityZip Code

County: Cook

Telephone Number: (847) 741-1609Fax # (847) 622-5523

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X VOLUNTARY,NON-PROFIT

X Charitable Corp.
Trust

IRS Exemption Code 501c3

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 MelvinTelephone 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 07/01/2019 to 06/30/2020 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) Presidnet/CEO

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 Wasmond Center

0054445 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	57	Skilled Pediatric (SNF/PED)	57	20,862	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	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	20,450			20,450	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,450			20,450	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.03%

D. How many bed reserve days during this year were paid by the Department? 289 (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 11 / 1 /2016

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

Facility Name & ID Number Marklund Wasmond Center # 0054445 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	87,255	10,491	14,907	112,653		112,653		112,653			1
2	Food Purchase		122,806		122,806		122,806		122,806			2
3	Housekeeping	192,051	21,690	2,617	216,358		216,358		216,358			3
4	Laundry	75,992	17,420		93,412		93,412		93,412			4
5	Heat and Other Utilities			77,985	77,985		77,985		77,985			5
6	Maintenance	61,435	13,632	50,799	125,866		125,866		125,866			6
7	Other (specify):* Disposal Services			7,033	7,033		7,033		7,033			7
8	TOTAL General Services	416,733	186,039	153,341	756,113		756,113		756,113			8
	B. Health Care and Programs											
9	Medical Director			27,200	27,200		27,200		27,200			9
10	Nursing and Medical Records	3,045,289	273,304	84,844	3,403,437		3,403,437		3,403,437			10
10a	Therapy	151,164	2,803	20,170	174,137		174,137		174,137			10a
11	Activities	12,854	13,583		26,437		26,437		26,437			11
12	Social Services	18,002			18,002		18,002		18,002			12
13	CNA Training		618		618		618		618			13
14	Program Transportation	1,685		13,405	15,090		15,090		15,090			14
15	Other (specify):* Vision,Dental,Pharmacy & Pysch Consultants			14,342	14,342		14,342		14,342			15
16	TOTAL Health Care and Programs	3,228,994	290,308	159,961	3,679,263		3,679,263		3,679,263			16
	C. General Administration											
17	Administrative	83,999			83,999		83,999		83,999			17
18	Directors Fees											18
19	Professional Services			35,009	35,009		35,009	(13,295)	21,714			19
20	Dues, Fees, Subscriptions & Promotions			35,325	35,325		35,325	(10,293)	25,032			20
21	Clerical & General Office Expenses	132,332	107,010	34,520	273,862	(12,751)	261,111		261,111			21
22	Employee Benefits & Payroll Taxes			1,041,798	1,041,798		1,041,798		1,041,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,415	14,415		14,415	(4,921)	9,494			24
25	Other Admin. Staff Transportation			4,711	4,711		4,711	(14,204)	(9,493)			25
26	Insurance-Prop.Liab.Malpractice			81,702	81,702		81,702		81,702			26
27	Other (specify):* Bad Debt			8,984	8,984		8,984	(8,984)				27
28	TOTAL General Administration	216,331	107,010	1,256,464	1,579,805	(12,751)	1,567,054	(51,697)	1,515,357			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,862,058	583,357	1,569,766	6,015,181	(12,751)	6,002,430	(51,697)	5,950,733			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			325,202	325,202		325,202	(20,535)	304,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,809	3,809		3,809	(3,809)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					12,751	12,751		12,751			35
36	Other (specify):*											36
37	TOTAL Ownership			329,011	329,011	12,751	341,762	(24,344)	317,418			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			331,360	331,360		331,360		331,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			331,360	331,360		331,360		331,360			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,862,058	583,357	2,230,137	6,675,552		6,675,552	(76,041)	6,599,511			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	(3,809)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,153)	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	(13,295)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,984)	27		24
25	Fund Raising, Advertising and Promotional	(8,140)	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	(39,660)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,041)		\$	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))	\$ (76,041)		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	\$ (4,921)	24	1
2	Travel & Sustenance	(14,204)	25	2
3	Depreciation	(20,535)	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
17				17
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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	(39,660)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Wasmond Center# 0054445

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	(13,295)	0	0	0	0	0	0	0	0	0	0	(13,295)	19
20	Fees, Subscriptions & Promotions	(10,293)	0	0	0	0	0	0	0	0	0	0	(10,293)	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	(4,921)	0	0	0	0	0	0	0	0	0	0	(4,921)	24
25	Other Admin. Staff Transportation	(14,204)	0	0	0	0	0	0	0	0	0	0	(14,204)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,984)	0	0	0	0	0	0	0	0	0	0	(8,984)	27
28	TOTAL General Administration	(51,697)	0	0	0	0	0	0	0	0	0	0	(51,697)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(51,697)	0	0	0	0	0	0	0	0	0	0	(51,697)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Wasmond Center # 0054445 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	(20,535)	0	0	0	0	0	0	0	0	0	0	(20,535)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,809)	0	0	0	0	0	0	0	0	0	0	(3,809)	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	(24,344)	0	0	0	0	0	0	0	0	0	0	(24,344)	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)	(76,041)	0	0	0	0	0	0	0	0	0	0	(76,041)	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
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16								16
17								17
18								18
19								19
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Wasmond Center # 0054445 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 Wasmond Center
--------------------------------------	--------------------------------

0054445

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	18,957,695	18,957,695	\$ 63	\$	6,300,918	\$ 21	1
2	2	Food	Direct Cost Budget	18,957,695	18,957,695	977		6,300,918	325	2
3	3	Housekeeping	Direct Cost Budget	18,957,695	18,957,695	4,584		6,300,918	1,524	3
4	5	Utilities	Direct Cost Budget	18,957,695	18,957,695	24,863		6,300,918	8,264	4
5	6	Maintenance	Direct Cost Budget	18,957,695	18,957,695	18,017		6,300,918	5,988	5
6	7	Disposal	Direct Cost Budget	18,957,695	18,957,695	1,292		6,300,918	429	6
7	13	BNATP	Direct Cost Budget	18,957,695	18,957,695	1,559		6,300,918	518	7
8	14	Transportation	Direct Cost Budget	18,957,695	18,957,695	0		6,300,918	0	8
9	19	Professional Services	Direct Cost Budget	18,957,695	18,957,695	98,000		6,300,918	32,572	9
10	20	Fees,Subscription	Direct Cost Budget	18,957,695	18,957,695	124,826		6,300,918	41,488	10
11	21	Clerical/Office	Direct Cost Budget	18,957,695	18,957,695	1,051,451	627,717	6,300,918	349,468	11
12	22	Benefits	Direct Cost Budget	18,957,695	18,957,695	169,328		6,300,918	56,279	12
13	24	Travel & Seminar	Direct Cost Budget	18,957,695	18,957,695	6,943		6,300,918	2,308	13
14	25	Staff Transportation	Direct Cost Budget	18,957,695	18,957,695	4,837		6,300,918	1,608	14
15	26	Insurance	Direct Cost Budget	18,957,695	18,957,695	32,682		6,300,918	10,862	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		\$ 511,654	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 Wasmond Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054445

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: 16,776

B. General Construction Type: Exterior Block/BrickFrame Brick/AluminumNumber 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).

Marklund Day School

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	114,840	2016	\$ 460,000	1
2					2
3	TOTALS	114,840		\$ 460,000	3

Facility Name & ID Number Marklund Wasmond Center

0054445

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		2016	1969	\$ 1,879,000	\$ 93,950	20	\$ 93,950	\$	\$ 328,825	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LI Marklund Wasmond Center -			2016	161,000	32,200	5	32,200		112,700	9
10	BI Flooring Wall Base Replacmnt			2017	5,291	529	10	529		1,852	10
11	LI Drain Basin Replacement			2017	1,830	122	15	122		427	11
12	BI Door Replacement Main & DT			2017	10,182	1,018	10	1,018		3,564	12
13	BI Rem & Rpl Carpet 2 Rms Cubicle			2017	5,107	1,021	5	1,021		3,575	13
14	BI 6 Data Drops New Cubicle Room			2017	1,000	333	3	333		833	14
15	BI Main Entr Sign Inst Portico			2017	385	77	5	77		192	15
16	LI Exterior Entrance Sign MWC			2017	12,654	1,055	12	1,055		2,636	16
17	LI Exterior Entrance Sign			2017	1,791	149	12	149		373	17
18	LI Exterior Entrance Sign Light			2017	1,197	120	10	120		299	18
19	LI Grind and Repavement Center			2017	21,744	1,450	15	1,450		3,624	19
20	LI Center Lot Sealct, Crack Strip			2017	1,675	419	2	419		1,675	20
21	BI Remove & Replace Siding Gable			2017	3,051	203	15	203		509	21
22	BI Interior Painting Client Room			2018	895	90	10	90		224	22
23	LI Flagpole 30'split w/MWC-DT			2018	1,750	117	15	117		292	23
24	BI replaced flooring with vinyl plank -Nurse entrance & Report Room			2018	2,282	456	5	456		685	24
25	BI replaced flooring w/vinyl flooring & base -corridor & resident srvc			2018	16,588	3,318	5	3,318		4,976	25
26	LI Flag Pole Lighting			2018	1,310	66	20	66		98	26
27	BI Fire Rated Door Basement			2018	1,073	215	5	215		322	27
28	BI Install Hospital Grade Receptacles			2018	11,617	1,162	10	1,162		1,742	28
29	BI 50 Replacemnt Hospital Grade Receptacle Covers			2018	2,193	219	10	219		329	29
30	BI Boiler Repair Parts Only			2019	827	165	5	165		248	30
31	BI Painting 5 Offices			2019	1,250	250	5	250		375	31
32	BI Lochinvar Copper Coil Boiler			2019	12,590	1,259	10	1,259		1,889	32
33	BI Cable Data Installation			2019	1,001	100	10	100		150	33
34	BI Ceiling Repair			2019	1,547	155	10	155		232	34
35	BI Painting 8 Bedrooms North Side			2019	7,160	1,432	5	1,432		2,148	35
36	BI replaced carpet w/carpet tiles & vinyl base 5 offices			2019	8,968	1,794	5	1,794		2,690	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Wasmond Center

0054445

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 Dental Office Flooring tile, cabinets, mirrors, electrical update	2019	\$ 14,608	\$ 1,461	5	\$ 1,461	\$	\$ 1,461	37
38	BI Remodel 3 Bathing Closet into wardrobes North side rms-patch	2019	27,324	1,366	10	1,366		1,366	38
39	install carpet tilrs, mirrors, remove fans,swap elect switches, outlets								39
40	BI Install Holby Mixing Valve	2019	3,010	301	10	301		301	40
41	BI Roof Coating & Flashing	2019	4,284	214	10	214		214	41
42	BI Toilet replacement	2020	970	97	5	97		97	42
43	BI Heat Exchanger Repair	2020	2,437	244	5	244		244	43
44	BI Heat Exchanger Repair	2020	2,437	244	5	244		244	44
45	BI mural removal - paint 2 wall sections & Great room	2020	1,790	179	10	179		179	45
46	BI Oxygen Storage Door Repair	2020	1,149	57	10	57		57	46
47	BI Flooring replacement Vestibule & walkoff w/carpet squares	2020	2,713	136	10	136		136	47
48	BI Make activity rm into bedroom: studs,drywall, paint, add sink	2020	4,518	226	10	226		226	48
49	BI Flooring Replacement w vinyl plank & Flotex East & North Ha	2020	24,587	1,229	10	1,229		1,229	49
50	BI panic button system Split w/16 bed Homes	2020	1,242	124	5	124		124	50
51	BI HVAC Repair	2020	1,290	129	5	129		129	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)		\$ 2,269,317	\$ 149,451		\$ 149,451	\$	\$ 483,491	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	\$ 610,804	\$ 116,065	\$ 116,065	\$	5	\$ 331,406	71
72	Current Year Purchases	204,398	23,037	23,037		5	23,037	72
73	Fully Depreciated Assets	18,428	3,072	3,072		5	18,428	73
74								74
75	TOTALS	\$ 833,630	\$ 142,174	\$ 142,174	\$		\$ 372,871	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	2008 Ford F250 Truck	2016	\$ 6,980	\$	\$	\$	5	\$ 6,980	76
77	Maintenance	2012 Ford Van	2016	4,544				5	4,544	77
78	Patient Transport	2010 Twn Cnty Minivan	2016	6,934				5	6,934	78
79	Patient Transport	2017 El Dorado E250 Bus	2017	65,208	13,042	13,042		5	32,604	79
80	TOTALS			\$ 83,666	\$ 13,042	\$ 13,042	\$		\$ 51,062	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,646,613	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 304,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 304,667	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 907,424	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:n/a
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☒ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy:

☐ YES☒ NO

Terms:*

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

15. Is Movable equipment rental included in building rental?

☐ YES☒ NO
16. Rental Amount for movable equipment:\$12,751Description: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

C. CONTRACTUAL INCOME

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)	\$			

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 (spe 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)	1,827,921	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	1,977,095	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 Wasmond Center

0054445

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	\$ 8,177,089	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,177,089	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	16,666	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)	\$ 16,666	23
	D. Non-Operating Revenue		
24	Contributions	309,718	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 309,718	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)	\$ 8,503,473	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	756,113	31
32	Health Care	3,679,263	32
33	General Administration	1,579,805	33
	B. Capital Expense		
34	Ownership	329,011	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	331,360	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,675,552	40
41	Income before Income Taxes (line 30 minus line 40)**	1,827,921	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,827,921	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,989,042	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	188,047	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,177,089	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	1,581	1,664	\$ 59,272	\$ 35.62	1
2	Assistant Director of Nursing	3,952	4,160	145,600	35.00	2
3	Registered Nurses	35,533	37,403	1,207,375	32.28	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	77,657	81,744	1,491,832	18.25	5
6	CNA Trainees					6
7	Licensed Therapist	3,359	3,536	151,164	42.75	7
8	Rehab/Therapy Aides					8
9	Activity Director	593	624	12,854	20.60	9
10	Activity Assistants					10
11	Social Service Workers	593	624	18,002	28.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,022	2,128	40,199	18.89	14
15	Cook Helpers/Assistants	1,927	2,028	34,476	17.00	15
16	Dishwashers	1,037	1,092	12,580	11.52	16
17	Maintenance Workers	2,518	2,650	61,435	23.18	17
18	Housekeepers	11,057	11,639	192,051	16.50	18
19	Laundry	4,992	5,255	75,992	14.46	19
20	Administrator	1,581	1,664	83,999	50.48	20
21	Assistant Administrator					21
22	Other Administrative	296	312	40,753	130.62	22
23	Office Manager					23
24	Clerical	3,557	3,744	91,578	24.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,533	5,824	108,326	18.60	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,080	32,885	15.81	31
32	Other Health Care(specify)	119	125	1,685	13.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,883	168,296	\$ 3,862,058 *	\$ 22.95	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	77	\$ 7,414	1	35
36	Medical Director	monthly	27,200	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	5,567	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	288	20,170	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	varies	8,573	15	46
47	Vision	visit	203	15	47
48					48
49	TOTAL (lines 35 - 48)	365	\$ 69,126		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	611	\$ 40,396	10	50
51	Licensed Practical Nurses	460	21,126	10	51
52	Certified Nurse Assistants/Aides	935	23,322	10	52
53	TOTAL (lines 50 - 52)	2,005	\$ 84,844		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? yes
If YES, give association name and amount. Illinois Healthcare Association , \$3,395
- (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. \$ 35,606 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. \$ 331,360
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	Cannon	iR1435iF	3
Copier	Cannon	C3330i	1

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