

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0047266

Facility Name: Marklund Richard Home

Address: 1 South 410 Wyatt Dr Geneva 60134

County: Kane

Telephone Number: (630) 593-5161 Fax # (630) 397-5166

HFS ID Number:

Date of Initial License for Current Owners: 6/9/06

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 Melvin

Telephone Number: (630) 593 5485

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2024 to 06/30/2025 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)

(Type or Print Name) Gilbert W. Fonger

(Title) President/CEO

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number

Marklund Richard Home

0047266

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,651							5,651	13
14	TOTALS	5,651							5,651	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

96.76%

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

162 (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 06/16/06

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 certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐ NO ☐

Tax Year: 06/30/2025 Fiscal Year: 06/30/2025

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

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	19,518	1,932	3,582	25,032		25,032		25,032			1
2	Food Purchase		61,514		61,514		61,514		61,514			2
3	Housekeeping	27,334	3,082	157	30,573		30,573		30,573			3
4	Laundry	21,070	2,235		23,305		23,305		23,305			4
5	Heat and Other Utilities			32,363	32,363		32,363		32,363			5
6	Maintenance	33,086	4,688	19,065	56,839		56,839		56,839			6
7	Other (specify):*			2,566	2,566		2,566		2,566			7
8	TOTAL General Services	101,008	73,451	57,733	232,192		232,192		232,192			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	912,322	77,475	178,809	1,168,606		1,168,606		1,168,606			10
10a	Therapy	89,046	432	138	89,616		89,616		89,616			10a
11	Activities	14,258	6,188		20,446		20,446		20,446			11
12	Social Services	5,226			5,226		5,226		5,226			12
13	CNA Training		1,901		1,901		1,901		1,901			13
14	Program Transportation			21,351	21,351		21,351		21,351			14
15	Other (specify):*			2,923	2,923		2,923		2,923			15
16	TOTAL Health Care and Programs	1,020,852	85,996	208,221	1,315,069		1,315,069		1,315,069			16
	C. General Administration											
17	Administrative	28,576			28,576		28,576		28,576			17
18	Directors Fees											18
19	Professional Services			9,121	9,121		9,121	(2,410)	6,711			19
20	Dues, Fees, Subscriptions & Promotions			12,080	12,080		12,080	(3,484)	8,596			20
21	Clerical & General Office Expenses	169,793	33,972	8,103	211,868	(1,889)	209,979		209,979			21
22	Employee Benefits & Payroll Taxes			225,084	225,084		225,084		225,084			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,286	2,286		2,286	(2,286)				24
25	Other Admin. Staff Transportation			1,274	1,274		1,274	(1,274)				25
26	Insurance-Prop.Liab.Malpractice			40,087	40,087		40,087		40,087			26
27	Other (specify):*			2,500	2,500		2,500	(2,500)				27
28	TOTAL General Administration	198,369	33,972	300,535	532,876	(1,889)	530,987	(11,954)	519,033			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,320,229	193,419	566,489	2,080,137	(1,889)	2,078,248	(11,954)	2,066,294			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			115,747	115,747		115,747	(16,313)	99,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,724	7,724		7,724	(7,724)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					1,889	1,889		1,889			35
36	Other (specify):*											36
37	TOTAL Ownership			123,471	123,471	1,889	125,360	(24,037)	101,323			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			117,192	117,192		117,192		117,192			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			117,192	117,192		117,192		117,192			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,320,229	193,419	807,152	2,320,800		2,320,800	(35,991)	2,284,809			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	(7,724)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(896)	20		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	(2,410)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,500)	27		24
25	Fund Raising, Advertising and Promotional	(29)	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	(22,184)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,743)		\$	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))	\$ (35,743)		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Seminars	(1,429)	24	3
4	Travel & Sustenance	(857)	24	4
5	Mileage	(1,274)	25	5
6	Depreciation	(16,313)	30	6
7	Dues & Subscriptions	(1,625)	20	7
8	Bank Fees	(934)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,432)		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[illegible]

VII. RELATED PARTIES

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

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

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		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 (continued)

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)	
15	V		n/a	\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Ownership Listing-1

ID# 0047266

07/01/2024

06/30/2025

Co. / Home Office

Ownership Percentage

[illegible]

STATE OF ILLINOIS

Ownership Listing-2

Marklund Richard Home

ID#0047266

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

76	n/a							76
77								77
78								78
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150								150

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	n/a							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	n/a						\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	n/a												6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	n/a												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Assessed Value from Real Estate Tax Bill:		2024		8	
Real Estate Tax Bill for Calendar Year:		2020		9	
		2021		10	
		2022		11	
		2023		12	
		2024		13	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Marklund Richard Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047266

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (630) 593-5487 FAX #: (630) 593-5501

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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.)

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:

8,815

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 Centrer Day Training 43,000 sf 112 preson capacity

Marklund Sayers Home 16 bed facility 8315 sf 16 person capacity

Marklund Haverkamp Home 16 bed facility 8315 sf 16 person capacity

Marklund Dreher Home 16 bed facility 8315sf 16 person capacity

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

Marklund Tommy Home 16 bed facility 8315 sf 16 person capacity

F. List the bed capacity for the building if it differs from the licensed total.

n/a

G. Have you properly capitalized all major repairs and equipment purchases?

yes

H. Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

no

J. 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.

K. 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	116,479	2006	\$ 329,981	1
2					2
3	TOTALS	116,479		\$ 329,981	3

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

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	LI Replace Fence Posts - split evenly 16 bed homes	2019	\$ 283	\$	5	\$	\$	\$ 283	37
38	BI AC Compressor Repair	2019	1,193		5			1,193	38
39	BI Interior Painting - Bedrooms	2019	4,835	483	5	483		4,835	39
40	BI Window Blind Replacement	2019	318	33	5	33		318	40
41	BI Repair 4' kitchen floor pipe break	2019	1,583	158	10	158		870	41
42	BI Flooring Replacement in common aress with vinyl plank and	2020	41,566	4,157	10	4,157		22,863	42
43	bedrooms with Flotex								43
44	BI Washing Machine Waterline Repair	2020	208	20	5	20		208	44
45	BI Panic Button System Split - 16 bed Homes	2020	801	81	5	81		801	45
46	BI Nurses station Countertop Replacement Split w/MDH	2021	889	89	10	89		400	46
47	BI HVAC Compressor Line Dryer Replacement	2021	2,315	463	5	463		2,084	47
48	LI Remove & Replace Posts Trash Bin Split MDH	2021	825	82	10	82		370	48
49	BI Home painting Common Area	2022	4,795	799	5	799		2,797	49
50	BI Moving and adding network drops cubical room	2022	112	11	10	11		39	50
51	LI Hunzinger Williams Gable Style Canopy	2022	899	180	5	180		450	51
52	LI Baseball Field Dugout Awning Replacement	2023	647	129	5	129		323	52
53	BI Replace compressor, contractor, crankcase	2023	3,210	321	10	321		803	53
54	BI Re-roofing Woodshed at Campsite	2024	515	51	10	51		77	54
55	BI refeeding condensing units 150A MCB 120/209V Panel from ge	2024	870	87	10	87		131	55
56	BI Replacement of Gable Style Canopy with Frame for Storage sh	2024	571	94	10	94		141	56
57	BI Repaint Exterior Siding	2024	7,250	1,450	15	1,450		2,175	57
58	BI Installation of 12 LED Food lights	2024	1,333	133	5	133		200	58
59	LI Replace MHC Baseball Field turf	2025	37,856	1,893	10	1,893		1,893	59
60	BI Install Shower Trolleys in Bathrooms	2025	5,332	267	10	267		267	60
61	BI Install Shower Panels in Bathrooms	2025	2,636	118	10	118		118	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,714,671	\$ 82,537		\$ 82,537	\$	\$ 1,599,242	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	\$66,491	\$14,508	\$14,508	\$		\$38,961	71
72	Current Year Purchases	4,998	378	378			378	72
73	Fully Depreciated Assets	214,812	2,011	2,011			214,812	73
74								74
75	TOTALS	\$286,301	\$16,897	\$16,897	\$		\$254,151	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	76
77	Patient Transport	2014 Ford Ambulette Van 1/6	2014	5,978				5	5,978	77
78	Patient Transport	2016 Ford E350 Bus 1/3	2016	19,553				5	19,553	78
79	Patient Transport	2017 El Dorado Bus 1/6	2018	10,435				5	10,435	79
80	TOTALS			\$40,552	\$	\$	\$		\$40,552	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)	\$2,371,505	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$99,434	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$99,434	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)	\$1,893,945	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: \$1,889
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	n/a		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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	n/a	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.

Facility Name & ID Number	Marklund Richard Home
--------------------------------------	------------------------------

0047266

Report Period Beginning: 07/01/2024

Ending:

06/30/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2025

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,994,830	\$ 2,994,830	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (453,818))	6,784,116	6,784,116	3
4	Supply Inventory (priced at)	169,792	169,792	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	603,707	603,707	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Accounts	615,112	615,112	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 11,167,557	\$ 11,167,557	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,306,378	17,306,378	12
13	Land	10,098,108	10,098,108	13
14	Buildings, at Historical Cost	45,296,926	45,296,926	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	7,977,798	7,977,798	16
17	Accumulated Depreciation (book methods)	(33,508,521)	(33,508,521)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	8,544,230	8,544,230	21
22	Other Long-Term Assets (specify):	16,739,893	16,739,893	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 72,454,812	\$ 72,454,812	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 83,622,369	\$ 83,622,369	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 693,269	\$ 693,269	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	687,413	687,413	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	17,037	17,037	33
34	Deferred Compensation	2,448,035	2,448,035	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accued lease liability</u>	65,843	65,843	36
37	<u>accrued liability other</u>	2,092,739	2,092,739	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,004,336	\$ 6,004,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,065,807	10,065,807	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Line of Credit Payable</u>	6,250,536	6,250,536	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,316,343	\$ 16,316,343	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,320,679	\$ 22,320,679	46
47	TOTAL EQUITY(page 18, line 24)	\$ 61,301,690	\$ 61,301,690	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 83,622,369	\$ 83,622,369	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 58,152,279	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 58,152,279	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	343,035	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,049,755	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	60,478	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,453,268	17
	B. Transfers (Itemize):		
18		1,696,143	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,696,143	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 61,301,690	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

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	\$ 2,073,491	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,073,491	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	11,967	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)	\$ 11,967	23
	D. Non-Operating Revenue		
24	Contributions	578,377	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 578,377	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)	\$ 2,663,835	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	232,192	31
32	Health Care	1,315,069	32
33	General Administration	532,876	33
	B. Capital Expense		
34	Ownership	123,471	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	117,192	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,320,800	40
41	Income before Income Taxes (line 30 minus line 40)**	343,035	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 343,035	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,902,764.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) SSA	170,727.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,073,491	56

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	\$ 12,227	\$ 42.02	1
2	Assistant Director of Nursing	1,378	1,450	53,649	37.00	2
3	Registered Nurses	5,779	6,083	225,077	37.00	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	23,095	24,311	563,773	23.19	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,077	1,134	44,366	39.12	7
8	Rehab/Therapy Aides	2,391	2,517	44,681	17.75	8
9	Activity Director	164	173	4,810	27.80	9
10	Activity Assistants	296	312	9,447	30.28	10
11	Social Service Workers	164	173	5,226	30.21	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	316	333	7,541	22.65	14
15	Cook Helpers/Assistants	340	358	6,093	17.02	15
16	Dishwashers	340	358	5,885	16.44	16
17	Maintenance Workers	1,131	1,191	33,086	27.78	17
18	Housekeepers	1,672	1,760	27,334	15.53	18
19	Laundry	1,258	1,324	21,070	15.91	19
20	Administrator	336	354	19,307	54.54	20
21	Assistant Administrator	296	312	9,270	29.71	21
22	Other Administrative	4,019	4,230	150,426	35.56	22
23	Office Manager	0	0	0		23
24	Clerical	721	759	19,367	25.52	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified ID Prof (QIDP)	1,976	2,080	52,603	25.29	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	247	260	4,992	19.20	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	47,272	49,763	\$ 1,320,230 *	\$ 26.53	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	64	\$ 3,207	1	35
36	Medical Director	monthly	5,000	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,607	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	varies	138	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Medical Doctor Consult	2	170	15	46
47	Vision	visit	358	15	47
48	Dental	visit	788	15	48
49	TOTAL (lines 35 - 48)	66	\$ 11,268		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	212	\$ 16,560	10	50
51	Licensed Practical Nurses	0	0	10	51
52	Certified Nurse Assistants/Aides	3,818	162,249	10	52
53	TOTAL (lines 50 - 52)	4,030	\$ 178,809		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

no
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	1,395
	1,395 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	
	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	1,395
	1,395 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	22,599	Line	10
----	--------	------	----
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	117,192
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

If YES, attach an explanation of the allocation.

- (9)

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
- (10)

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.
- (11)

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.	\$	
----	-----	--	-----	----------------------	----	--
- (12)

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?

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?

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.

\$
- (13)

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

Firm Name: KPMG

yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes
- (15)

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.

no

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	Konica	ADXJ013002374	1

2025 Marklund Board of Directors

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