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: 0045567

Facility Name: Marklund Tommy Home

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

County: Kane

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

HFS ID Number:

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

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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) _____ (Date)
(Type or Print Name) Gilbert W. Fonger
(Title) President/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
2200 Churchill Rd.
Springfield, IL 62702-3406 **Phone # (217) 782-1630**

Facility Name & ID Number Marklund Tommy Home # 0045567 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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.

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	9
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,427							5,427	13
14	TOTALS	5,427							5,427	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.93%

D. How many bed reserve days during this year were paid by the Department?
31 (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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/18/03

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] 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 Tommy Home # 0045567 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	20,741	1,912	3,582	26,235		26,235		26,235			1
2	Food Purchase		68,100		68,100		68,100		68,100			2
3	Housekeeping	27,325	3,082	157	30,564		30,564		30,564			3
4	Laundry	21,077	1,832		22,909		22,909		22,909			4
5	Heat and Other Utilities			30,481	30,481		30,481		30,481			5
6	Maintenance	20,037	4,428	22,863	47,328		47,328		47,328			6
7	Other (specify):*			2,566	2,566		2,566		2,566			7
8	TOTAL General Services	89,180	79,354	59,649	228,183		228,183		228,183			8
	B. Health Care and Programs											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	942,683	66,887	163,846	1,173,416		1,173,416		1,173,416			10
10a	Therapy	89,038	307	303	89,648		89,648		89,648			10a
11	Activities	14,252	5,524		19,776		19,776		19,776			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):*			2,676	2,676		2,676		2,676			15
16	TOTAL Health Care and Programs	1,051,199	74,619	193,176	1,318,994		1,318,994		1,318,994			16
	C. General Administration											
17	Administrative	27,440			27,440		27,440		27,440			17
18	Directors Fees											18
19	Professional Services			9,121	9,121		9,121	(2,410)	6,711			19
20	Dues, Fees, Subscriptions & Promotions			12,081	12,081		12,081	(3,228)	8,853			20
21	Clerical & General Office Expenses	169,793	34,331	8,103	212,227	(1,889)	210,338		210,338			21
22	Employee Benefits & Payroll Taxes			228,429	228,429		228,429		228,429			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,707	1,707		1,707	(1,707)				24
25	Other Admin. Staff Transportation			870	870		870	(870)				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	197,233	34,331	302,898	534,462	(1,889)	532,573	(10,715)	521,858			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,337,612	188,304	555,723	2,081,639	(1,889)	2,079,750	(10,715)	2,069,035			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.

Facility Name & ID Number Marklund Tommy Home #0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			49,994	49,994		49,994	(16,902)	33,092			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		1,889			35
36	Other (specify):*											36
37	**TOTAL Ownership**			59,607	59,607		59,607	(24,626)	34,981			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			120,236	120,236		120,236		120,236			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			120,236	120,236		120,236		120,236			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,337,612	188,304	735,566	2,261,482	(1,889)	2,259,593	(35,341)	2,224,252			45

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

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	(21,790)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,349)		$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (35,349)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Marklund Tommy Home

ID# 0045567

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

	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	(934)	24	3
4	Travel & Sustenance	(773)	24	4
5	Mileage	(870)	25	5
6	Depreciation	(16,902)	30	6
7	Dues & Subscriptions	(1,369)	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
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(21,782)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	(2,410)	0	0	0	0	0	0	0	0	0	0	(2,410)	19
20	Fees, Subscriptions & Promotions	(3,228)	0	0	0	0	0	0	0	0	0	0	(3,228)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,707)	0	0	0	0	0	0	0	0	0	0	(1,707)	24
25	Other Admin. Staff Transportation	(870)	0	0	0	0	0	0	0	0	0	0	(870)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	27
28	**TOTAL General Administration**	(10,715)	0	0	0	0	0	0	0	0	0	0	(10,715)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,715)	0	0	0	0	0	0	0	0	0	0	(10,715)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Tommy Home # 0045567 **Report Period Beginning:** 07/01/2024 **Ending:** 06/30/2025

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,902)	0	0	0	0	0	0	0	0	0	0	(16,902)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,724)	0	0	0	0	0	0	0	0	0	0	(7,724)	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**	(24,626)	0	0	0	0	0	0	0	0	0	0	(24,626)	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)**	(35,341)	0	0	0	0	0	0	0	0	0	0	(35,341)	45

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

STATE OF ILLINOIS **Ownership Listing-1**

Marklund Tommy Home

ID# **0045567**

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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	n/a								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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STATE OF ILLINOIS **Ownership Listing-2**

Marklund Tommy Home

ID# **0045567**

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.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76	n/a								76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
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147									147
148									148
149									149
150									150

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

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

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

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 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	42,117,536	42117535.56	$ 0	$	2,044,245	$ 0	1
2	2	Food	Direct Cost Budget	42,117,536	42117535.56	930		2,044,245	45	2
3	3	Housekeeping	Direct Cost Budget	42,117,536	42117535.56	3,464		2,044,245	168	3
4	5	Utilities	Direct Cost Budget	42,117,536	42117535.56	43,028		2,044,245	2,088	4
5	6	Maintenance	Direct Cost Budget	42,117,536	42117535.56	20,908		2,044,245	1,015	5
6	7	Disposal	Direct Cost Budget	42,117,536	42117535.56	1,807		2,044,245	88	6
7	13	BNATP	Direct Cost Budget	42,117,536	42117535.56	25,084		2,044,245	1,217	7
8	14	Transportation	Direct Cost Budget	42,117,536	42117535.56	218,809		2,044,245	10,620	8
9	19	Professional Services	Direct Cost Budget	42,117,536	42117535.56	125,004		2,044,245	6,067	9
10	20	Fees,Subscription	Direct Cost Budget	42,117,536	42117535.56	171,785		2,044,245	8,338	10
11	21	Clerical/Office	Direct Cost Budget	42,117,536	42117535.56	3,256,163	2,729,065	2,044,245	158,043	11
12	22	Benefits	Direct Cost Budget	42,117,536	42117535.56	675,721		2,044,245	32,797	12
13	24	Travel & Seminar	Direct Cost Budget	42,117,536	42117535.56	11,451		2,044,245	556	13
14	25	Staff Transportation	Direct Cost Budget	42,117,536	42117535.56	4,878		2,044,245	237	14
15	26	Insurance	Direct Cost Budget	42,117,536	42117535.56	59,470		2,044,245	2,886	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,618,502	$ 2,729,065		$ 224,165	25

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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.)

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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

	FOR BHF USE ONLY		
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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Tommy Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045567

CONTACT PERSON REGARDING THIS REPORT

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 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.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

Facility Name & ID Numb Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,315 B. General Construction Type: Exterior Brick/Cedar Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity? [x] (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? [x] (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 Haverkampf Home 16 bed facility 8315 sf 16 person capacity Marklund Richard Home 16 Bed facility 8815 sf 16 person capacity
Marklund Van Der Molen Home 16 bed facility 8315 sf 16 perspn capcity
Marklund Sayers Home 16 bed facility 8315 sf 16 person capacity

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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	32,700	2003	$ 258,800	1
2					2
3	TOTALS	32,700		$ 258,800	3

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 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 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	16		2003	2003	$ 1,225,273	$	20	$	$	$ 1,225,273	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LI ALLOCATION OF LAND IMPROVMNTS			2003	62,119		10			62,119	9
10	BI MAGNETIC DOOR HOLDERS FUNDED			2003	2,822		5			2,822	10
11	BI INSTALLATION OF INCANDESCENT			2003	400		5			400	11
12	BI Gutter installation-patio			2004	383		5			383	12
13	LI Grading/Seeding Land Parcel			2004	301		5			301	13
14	BI Bollard Lighting			2004	1,300		5			1,300	14
15	LI Emerg Battery Lights-Generator			2005	333		10			333	15
16	LI CONCRETE SLABS BY DUMPSERS-4			2006	1,950		5			1,950	16
17	BI WALL CARPETIING			2006	5,484		5			5,484	17
18	BI EPOXY FLOORING INSTALLATION			2007	5,420		5			5,420	18
19	BI TILE INSTALLATION UNDER			2007	771		5			771	19
20	BI LIGHTNING PROTECTION SYSTEM			2008	3,100		5			3,100	20
21	BI INSTALLATION CORIAN BASEBRD &			2008	23,700		5			23,700	21
22	LI INSTALLATION OF 2 BALLARD LGHT			2008	637		5			637	22
23	BI Oak Plywood Shelving (4)/			2008	1,045		5			1,045	23
24	BI Sprinkler Sys Repair incl Air			2009	2,038		5			2,038	24
25	BI Corian Baseboard Trim/Carpet			2009	12,850		5			12,850	25
26	LI REPLACEMNT OF DUMPSTER GATE			2010	166		5			166	26
27	BI DOOR/THRESHOLD REPLACEMENT			2010	3,623		5			3,623	27
28	LI REPLACE ASPHALT SIDEWALKS WITH			2010	4,667		10			4,667	28
29	LI Asphalt Repairs-North Approach			2011	1,217		5			1,217	29
30	LI Replacement-Asphalt Sidewalks			2011	4,501		10			4,501	30
31	LI Asphalt Repairs near Ballfield			2011	163		5			163	31
32	BI Gutter Extension over Patio			2011	423		5			423	32
33	LI WheelChair Glider W/ Concrete			2012	1,562		5			1,562	33
34	BI Replacement of Floor Covering			2012	38,189		5			38,189	34
35	LI CONCRETE REPLACEMENT OF			2013	2,833		10			2,833	35
36	LI PHASE III REPLACE ASPHALT W/ CONCRETE			2014	4,017	202	10	202		4,017	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 Tommy Home # 0045567 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BI Window & Sash Replacement	2014	$ 13,042	$	5	$	$	$ 13,042	37
38	BI Lamp flourescent Drum Fixture	2016	822	83	5	83		782	38
39	BI Data Line Install 10line 5dp	2016	78	8	10	8		67	39
40	BI Electric Outlet Orient Room &	2016	169	3	20	3		28	40
41	BI CARPETING-NEW ORIENTATION ROOM	2016	288		5			288	41
42	LI Sink Hole Rpr Basebll Fld	2017	417	35	12	35		296	42
43	LI Outdoor Signage New Logo	2017	1,697	142	12	142		1,062	43
44	LI Sink Home Repair Baseball Fld	2017	983	82	12	82		615	44
45	LI Grind and Repavement parking lot	2017	712	47	15	47		355	45
46	LI Concrete Replacement West side	2017	1,072	43	25	43		322	46
47	BI Install 3 LED Fixt W/ Dimmer	2018	1,150	115	10	115		863	47
48	BI Painting Common Area,Main Entry	2018	4,170		5			4,170	48
49	LI Sealcoating, Crackfl, Strip Parking lot	2018	1,482		2			1,482	49
50	LI Replace Fence Posts Spt Evenly	2019	283	29	5	29		283	50
51	BI Window Blind Replacement	2019	318	33	5	33		318	51
52	BI Interior Painting Bedrooms	2019	4,835		5			4,835	52
53	BI Repair 4'kichen flr pipe break	2019	1,583	158	10	158		870	53
54	BI Washing Machine Waterline Rep	2020	208	20	5	20		208	54
55	BI Panic Button System Splt Homes	2020	801	80	5	80		801	55
56	BI Window Replacement south wall common area	2021	32,475	3,248	10	3,248		14,615	56
57	BI Moving and adding network drops in cubicle3	2021	112	11	10	11		39	57
58	BI Relocation intercom station split 4 Homes	2022	614	61	10	61		214	58
59	BI Kitchen Sewer Pipe Repair & Replacement	2022	525	46	20	46		115	59
60	BI Ball Field Dugout Canopy Replacement Restricted	2022	899	180	5	180		450	60
61	BI Baseball Field Dugout Awning Replacement	2023	647	129	5	129		323	61
62	BI Re-roofing Woodshed at Campsite	2024	515	51	10	51		77	62
63	BI refeeding condesning units 150A MCB 120/209V Panel from ge	2024	870	87	10	87		131	63
64	BI Replacement and install of Gable Style Canopy with Frame for	2024	571	94	15	94		141	64
65	BI Repaint Exterior Siding	2024	7,250	1,450	5	1,450		2,175	65
66	BI Installation of 12 LED outdoor Flood lights	2024	1,333	133	10	133		200	66
67	LI Replace MHC Baseball Field turf	2025	37,856	1,893	10	1,893		1,893	67
68	BI Removal and Installation of flooring and carpet	2025	40,584	3,246	10	3,246		3,246	68
69	BI Install Shower Trolleys in Bathrooms	2025	5,332	267	10	267		267	69
70	TOTAL (lines 4 thru 69)		$ 1,574,981	$ 11,976		$ 11,976	$	$ 1,465,860	70

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

Facility Name & ID Number Marklund Tommy Home # 0045567 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,574,981	$ 11,976		$ 11,976	$	$ 1,465,860	1
2	BI Install Shower Panels in Bathrooms	2025	2,636	118	10	118		118	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,577,617	$ 12,094		$ 12,094	$	$ 1,465,978	34

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

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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	$ 115,342	$ 18,886	$ 18,886	$		$ 81,913	71
72	Current Year Purchases	5,576	474	474			474	72
73	Fully Depreciated Assets	117,801	1,638	1,638			117,801	73
74								74
75	TOTALS	$ 238,719	$ 20,998	$ 20,998	$		$ 200,188	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	$	$	$		$ 4,586	76
77	Patient Transport	2014 Ford Ambulette Van 1/6	2014	5,978					5,978	77
78	Patient Transport	2016 El Dorado Bus 1/3	2016	21,045					21,045	78
79	Patient Transport	2017 El Dorado Bus 1/6	2018	10,435					10,435	79
80	TOTALS			$ 42,044	$	$	$		$ 42,044	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)	$ 2,117,180	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,092	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,092	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)	$ 1,708,209	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.

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: b/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 [x] 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. n/a
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

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	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 1,889 Description: Office Equipment/Machinery
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
[x] 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.

Facility Name & ID Number Marklund Tommy Home | STATE OF ILLINOIS # 0045567 | Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Tommy Home **#** 0045567 **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	accued lease liabilty	65,843	65,843	36
37	accrued liability other	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	Line of Credit Payable	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.)**

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

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)	(963,997)	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**	1,367,510	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,453,268	17
	B. Transfers (Itemize):		
18	**transfers out in to operations-expenses**	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 Tommy Home # 0045567 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,189,527	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,189,527	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	9,016	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)**	$ 9,016	23
	D. Non-Operating Revenue		
24	Contributions	189,753	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 189,753	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)**	$ 2,388,296	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,318,994	31
32	Health Care	1,318,994	32
33	General Administration	534,462	33
	B. Capital Expense		
34	Ownership	59,607	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	120,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,352,293	40
41	**Income before Income Taxes (line 30 minus line 40)****	(963,997)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (963,997)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,026,719.00	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	162,808.00	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)	$ 2,189,527	56

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	276	291	$ 12,225	$ 42.01	1
2	Assistant Director of Nursing	1,873	1,972	72,966	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	44,358	39.12	7
8	Rehab/Therapy Aides	2,391	2,517	44,681	17.75	8
9	Activity Director	164	173	4,805	27.77	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	336	354	8,013	22.64	14
15	Cook Helpers/Assistants	362	381	6,474	16.99	15
16	Dishwashers	362	381	6,254	16.41	16
17	Maintenance Workers	686	722	20,037	27.75	17
18	Housekeepers	1,671	1,759	27,325	15.53	18
19	Laundry	1,259	1,325	21,077	15.91	19
20	Administrator	316	333	18,171	54.57	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	63,648	30.60	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)	47,366	49,862	$ 1,337,612 *	$ 26.83	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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	303	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Medical Doctor Const	visit	0	15	46
47	Vision	visit	383	15	47
48	Dental	visit	686	15	48
49	TOTAL (lines 35 - 48)	64	$ 11,186		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	185	$ 14,431	10	50
51	Licensed Practical Nurses	561	42,058	10	51
52	Certified Nurse Assistants/Aides	2,526	107,358	10	52
53	TOTAL (lines 50 - 52)	3,272	$ 163,846		53

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Krissy Dolen	Administrator		$ 18,170
Gina Brancecum	Assistand Administrator		9,270
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,440

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	audit fees	$ 6,099
Dearborn National	outside service fees	612
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 6,711

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,052
Unemployment Compensation Insurance	
FICA Taxes	102,328
Employee Health Insurance	71,510
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	28,936
Dental	4,195
Life Insurance	1,173
Long Term Disability	11,235
TOTAL (agree to Schedule V, line 22, col.8)	$ 228,429

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,202
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	1,651
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,853

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Tommy Home # 0045567 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

XX. GENERAL INFORMATION:

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

(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)	1,651
	1,651 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)	1,651
	1,651 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 20,068 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. $ 120,236
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? no 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? yes

(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? _____ 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? 100

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. $ _____

(13) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: KPMG

(14) Have all costs which do not relate to the provision of long term care been adjusted out 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. n/a
Attach invoices and a summary of services for all architect and appraisal fees.

Type	Manufacturer	Model	Qty
Copier	Konica	ADXW013001773	1

2025 Marklund Board of Directors

Jim Armbruster
Maleeha Basha
Carie Carney
Carol Donahue
Gerry Estes
Karyn Fitch
Jerry Finis
Dan Foley
Mike Herlihy
Laura Karlins
Yaneth Medina
Frank Murnane Jr.
Julie Schrager
Ari Smith
Dan Whiston
David Van Daff