

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0033704</u></p> <p><b>Facility Name:</b> <u>Deicke Ctr-Marklund Chl Home</u></p> <p><b>Address:</b> <u>27 West 751 Shady Way</u> <u>Winfield</u> <u>60190</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>DuPage</u></p> <p><b>Telephone Number:</b> <u>(630)529-2018</u> <b>Fax #</b> <u>(630)529-9128</u></p> <p><b>IDPA ID Number:</b> <u>36-2652532</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/18/89</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501-(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Lisa Lipira</u> <b>Telephone Number:</b> <u>(630)529-2018 Ext. 2232</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501-(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/99</u> to <u>6/30/00</u> and certify to the best of my knowledge and belief that the said content 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</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table style="width:100%"> <tr> <td style="width:30%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ <u>10/14/00</u> <small>(Date)</small></td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Joel Rusco</u></td> </tr> <tr> <td></td> <td>(Title) <u>President &amp; CEO</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ <small>(Date)</small></td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE        ILLINOIS DEPARTMENT OF PUBLIC AID        201 S. Grand Avenue East        Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>10/14/00</u> <small>(Date)</small>		(Type or Print Name) <u>Joel Rusco</u>		(Title) <u>President &amp; CEO</u>	<b>Paid Preparer</b>	(Signed) _____ <small>(Date)</small>		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>																																						

DPA 3745 (N-4-99)

IL478-2471

**Print Preview**

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

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	42	Skilled Pediatric (SNF/PED)	42	15,372	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	42	TOTALS	42	15,372	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	14,800	366		15,166	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,800	366		15,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.66%

D. How many bed-hold days during this year were paid by Public Aid? 206 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 03/18/89

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAU  MODIFIED CASH\*  CASH\*

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

Tax Year: 7/1/99-6/30/00 Fiscal Year: 7/1/99-6/30/00  
\* All facilities other than governmental must report on the accrual basis.

Print Preview

**IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.**

STATE OF ILLINOIS

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00  
**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	155,201	6,922	7,771	169,894		169,894	0	169,894		1
2	Food Purchase		101,332		101,332		101,332	0	101,332		2
3	Housekeeping	89,274	15,560	19	104,853		104,853	0	104,853		3
4	Laundry	23,838	9,616		33,454		33,454	0	33,454		4
5	Heat and Other Utilities			54,058	54,058		54,058	0	54,058		5
6	Maintenance	44,359	12,625	37,037	94,021		94,021	0	94,021		6
7	Other (specify):*			12,368	12,368		12,368	0	12,368		7
8	<b>TOTAL General Services</b>	312,672	146,055	111,253	569,980		569,980		569,980		8
<b>B. Health Care and Programs</b>											
9	Medical Director			19,724	19,724		19,724	0	19,724		9
10	Nursing and Medical Records	959,960	104,450	42,800	1,107,210		1,107,210	0	1,107,210		10
10a	Therapy	270,882	6,610	23,728	301,220		301,220	0	301,220		10a
11	Activities	32,136	10,629	25,733	68,498		68,498	0	68,498		11
12	Social Services	41,673			41,673		41,673	0	41,673		12
13	Nurse Aide Training		0					0			13
14	Program Transportation			22,606	22,606		22,606	0	22,606		14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Programs</b>	1,304,651	121,689	134,591	1,560,931		1,560,931		1,560,931		16
<b>C. General Administration</b>											
17	Administrative	65,341			65,341		65,341	0	65,341		17
18	Directors Fees							0			18
19	Professional Services			12,939	12,939		12,939	0	12,939		19
20	Dues, Fees, Subscriptions & Promotions			38,309	38,309		38,309	0	38,309		20
21	Clerical & General Office Expenses	125,910	54,761	23,635	204,306		204,306	0	204,306		21
22	Employee Benefits & Payroll Taxes			392,073	392,073		392,073	0	392,073		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			3,748	3,748		3,748	0	3,748		24
25	Other Admin. Staff Transportation			8,768	8,768		8,768	0	8,768		25
26	Insurance-Prop. Liab. Malpractice			27,109	27,109		27,109	0	27,109		26
27	Other (specify):* <b>fundraising/promotional</b>			897,006	897,006		897,006	(897,006)			27
28	<b>TOTAL General Administration</b>	191,251	54,761	1,403,587	1,649,599		1,649,599	(897,006)	752,593		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,808,574	322,505	1,649,431	3,780,510		3,780,510	(897,006)	2,883,504		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

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			179,060	179,060		179,060	(57,289)	121,771			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			1,210	1,210	1,619	2,829	(2,829)				33
34	Rent-Facility & Grounds			21,683	21,683	(1,619)	20,064	0	20,064			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	<b>TOTAL Ownership</b>			201,953	201,953		201,953	(60,118)	141,835			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers	23,560	9,013		32,573		32,573	0	32,573			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			136,772	136,772		136,772	0	136,772			42
43	Other (specify):*							0				43
44	<b>TOTAL Special Cost Centers</b>	23,560	9,013	136,772	169,345		169,345		169,345			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,832,134	331,518	1,988,156	4,151,808	0	4,151,808	(957,124)	3,194,684			45

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

Print Preview

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning: 7/1/99

Ending: 6/30/00

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				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	(57,289)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(897,006)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,829)	33		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (957,124)		\$	30

OHF USE ONLY						
48		49	50	51	52	

Print Preview

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	2	
		Amount	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (957,124)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47



**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00  
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Summary A  
6/30/00

Print Summary A

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)
<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0 8
<b>B. Health Care and Programs</b>													
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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0 16
<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0 19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0 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	0	0	0	0	0	0	0	0	0	0	0	0 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006) 27
28	<b>TOTAL General Administration</b>	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006) 28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006) 29

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

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

Print Summary B

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	(57,289)	0	0	0	0	0	0	0	0	0	0	(57,289)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(2,829)	0	0	0	0	0	0	0	0	0	0	(2,829)	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	<b>TOTAL Ownership</b>	<b>(60,118)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(60,118)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(957,124)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(957,124)</b>	<b>45</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.



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.

Print Preview

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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	TOTALS				\$	\$		\$	25

[Print Preview](#)

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	N/A																			
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	N/A																			
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$	\$		\$											
<b>B. Non-Facility Related*</b>																				
10	N/A																			
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$											
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$											

\* 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.)

Print Preview

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	0	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.)	\$	0	2
3. Under or (over) accrual (line 2 minus line 1).	\$	0	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	0	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. 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. <b>TOTAL REFUND \$ <u>N/A</u> For 19 <u>    </u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	0	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<u>4,796</u>	<u>8</u>
	1996	<u>4,208</u>	<u>9</u>
	1997	<u>0</u>	<u>10</u>
	1998	<u>0</u>	<u>11</u>
	1999	<u>0</u>	<u>12</u>
<b>Note: The taxable property that related to calendar years 1995 - 1996 (see above) was sold in 11/96.</b>			

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Print Preview

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 10,520 B. General Construction Type: Exterior Brick Frame Single Story Number of Stories 2

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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	110,816	1988	\$ 100,000	1
2					2
3	TOTALS	110,816		\$ 100,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning:

7/1/99

Ending:

6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42		1987	1964	\$ 669,211	\$ 33,461	20	\$ 33,461	\$	\$ 418,257	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		Replacement of circular drive		1990	1,725		5			1,725	9
10		black top work on driveway		1992	2,484		5			2,484	10
11		resurfacing of parking lot		1993	810		5			810	11
12		removal/replacement of sidewalk		1994	600	60	5	60		600	12
13		stone bed work		1995	2,490	498	5	498		2,241	13
14		tree trimming/landscaping		1996	3,055		5			3,055	14
15		pavement,asphalt		1996	15,000	3,000	5	3,000		10,500	15
16		concrete ramp		1999	6,460	1,013	5	1,013		1,013	16
17		Security system		1988	2,055		10			2,055	17
18		renovations		1989	230,082	11,503	20	11,503		129,955	18
19		exterior canopy		1990	4,303	215	20	215		2,043	19
20		signage		1990	1,803	181	10	181		1,714	20
21		canopy sprinkler		1990	1,148	115	10	115		1,091	21
22		exterior staining		1991	2,650		5			2,650	22
23		storage shed		1992	899		5			899	23
24		windows		1993	5,838	584	10	584		4,379	24
25		retile tubs		1993	2,000		5			2,000	25
26		ac repair/renovation		1993	547		5			547	26
27		roof repair		1993	2,150		5			2,150	27
28		kitchen floor		1993	5,000		5			5,000	28
29		gutters, downspouts, soffit		1994	5,900	590	10	590		3,245	29
30		master key system		1994	607	61	5	61		607	30
31		tiling kitchen walls		1995	1,400	140	5	140		1,400	31
32		water heater		1995	3,765	376	5	376		2,071	32
33		anti freeze loop system for fire system		1999	2,532	101	25	101		152	33
34		interior painting & renovations		1999	4,250	850	5	850		1,275	34
35		new water close		1999	732	73	10	73		110	35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 52,821		\$ 52,821	\$	\$ 604,028	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

# 0033704

Report Period Beginning:

7/1/99

Ending:

Page 12A

6/30/00

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		vestibule addition		1999	42,700	4,270	10	4,270		6,405	9
10		exhaust fan		1999	2,000	133	15	133		200	10
11		siding		1999	2,135	427	5	427		641	11
12		fire alarm fitting		1999	312	13	25	13		19	12
13		auto doors new enclosure		1999	11,547	1,155	10	1,155		1,732	13
14		flooring new entrance		1999	1,383	277	5	277		415	14
15		painting & renovation		1999	2,650	530	5	530		795	15
16		air curtain		1999	767	153	5	153		230	16
17		air curtain		1999	934	187	5	187		280	17
18		flooring/carpeting		1999	42,747	8,549	5	8,549		12,824	18
19		soffits/ceiling/plumbing upgrades		1999	72,156	732	15	732		3,424	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		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$ 16,426		\$ 16,426	\$	\$ 26,965	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.

Print Preview

**IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.**

**Print Page 12B**

STATE OF ILLINOIS

# 0033704

Report Period Beginning:

7/1/99

Ending:

Page 12B

6/30/00

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$		\$	\$	\$	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.

**Print Preview**

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 196,835	\$ 28,611	\$ 28,611		3-10	\$ 135,038	37
38	Current Year Purchases	22,145	2,494	2,494		3-5	2,494	38
39	Fully Depreciated Assets	26,836				5	26,836	39
40								40
41	TOTALS	\$ 245,816	\$ 31,105	\$ 31,105			\$ 164,368	41

D. Vehicle Depreciation (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	
42	Maintenance	1994 ford van	1994	\$ 25,000	\$ 2,500	\$ 2,500		5	\$ 25,000	42
43	Gen. use	1996 ford 4X4	1996	20,537	4,107	4,107		5	14,375	43
44	Patient use	1999 Bluebird	1998	73,186	14,812	14,812		5	21,955	44
45										45
46	TOTALS			\$ 118,723	\$ 21,419	\$ 21,419			\$ 61,330	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 121,771	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 121,771	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 856,691	51

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

	1 Description & Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
52	Leasehold Improvements (1995,1996)	\$ 64,873	\$ 13,180	\$ 34,202	52
53	Equipment various years	230,474	44,109	199,183	53
54					54
55					55
56					56
57	TOTALS	\$ 295,347	\$ 57,289	\$ 233,385	57

G. Construction-in-Progress

	Description	Cost	
58	No Construction-in-Progress	\$	58
59	at year end related to this		59
60	facility		60
61		\$	61

\* 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.

Print Preview

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Berkson & Sons, Ltd.

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: <u>1980</u>	<u>0</u>	<u>4/96</u>	\$ <u>21,683</u>	<u>5</u>	<u>4</u>	3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>			\$ <b>21,683</b>			7

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 4,467 Description: various office equipment  
(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 4/96  
Ending 11/01

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

Fiscal Year Ending Annual Rent

12. base Pymts 6/30/2001 \$ 164,313  
13. base Pymts 6/30/2002 \$ 9,184  
14. /2003 \$ \_\_\_\_\_

\* 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.

Print Preview

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/99 Ending: 6/30/00

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>BNATP CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="text"/> <input type="text"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER AIDE _____ 50</p>	<p>3. <b>BNATP CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="text"/> <input type="text"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER AIDE _____ 80</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Print Preview

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	<a href="#">line 39, Col. 8</a>	1280 hrs.	23,560			9,013		32,573	12
13	Other (specify):									13
14	TOTAL			\$ 23,560		\$	\$ 9,013		\$ 32,573	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 nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Note: The Marklund organization does not keep separate Balance Sheets for individual residential sites. We have only one consolidated Balance Sheet for the organization.

Facility Name & ID Number **Deicke Ctr-Marklund Chl Home** # **0033704** Report Period Beginning: **7/1/99** Ending: **6/30/00**  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **6/30/00** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,893,350	\$ 1,893,350	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,000 )	2,006,062	2,006,062	3
4	Supply Inventory (priced at Cost )	47,355	47,355	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	47,355	47,355	6
7	Other Prepaid Expenses	63,727	63,727	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): <u>Client related funds</u>	363,398	363,398	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,421,247	\$ 4,421,247	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land/Land Improvements	1,041,178	1,041,178	13
14	Buildings/Build. Impr. , at Historical Cost	5,441,425	5,441,425	14
15	Leasehold Improvements, at Historical Cost	317,610	317,610	15
16	Equipment, at Historical Cost	3,083,232	3,083,232	16
17	Accumulated Depreciation (book methods)	(5,019,051)	(5,019,051)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	9,115,615	9,115,615	21
22	Other Long-Term Assets (specify): Board Restr.	1,349,213	1,349,213	22
23	Other(specify): <u>Construction in Progress</u>	116,732	116,732	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,445,954	\$ 15,445,954	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 19,867,201	\$ 19,867,201	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 433,777	\$ 433,777	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,654	149,654	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,140	11,140	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Misc. Other Accrued Liabilities</u>	1,392,746	1,392,746	36
37	<u>Client related liability</u>	363,398	363,398	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,350,715	\$ 2,350,715	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,350,715	\$ 2,350,715	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 17,516,486	\$ 17,516,486	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 19,867,201	\$ 19,867,201	48

\*(See instructions.)

Print Preview

Facility Name &amp; ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning: 7/1/99

Ending: 6/30/00

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 14,204,262	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 14,204,262	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,597,007)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,371,626	11
12	Expenditures for Specific Purposes	(388,427)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)General exp's related to temporarily restr. donations	(69,378)	15
16	Other (describe) Change in Unrealized Gains-other than trading securities	264,374	16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 1,581,188	17
<b>B. Transfers (Itemize):</b>			
18			18
19	<b>Restricted Funds (Permanently held)</b>	123,347	19
20	<b>Remaining Consolidated Income</b>	1,607,689	20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ 1,731,036	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 17,516,486	24 *

\* This must agree with page 17, line 47.

Print Preview

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning: 7/1/99

Ending: 6/30/00

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,547,798	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,547,798	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	7,003	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,003	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,554,801	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	\$ 569,980	31
32	Health Care	1,560,931	32
33	General Administration	1,649,599	33
<b>B. Capital Expense</b>			
34	Ownership	201,953	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	32,573	35
36	Provider Participation Fee	136,772	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,151,808	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,597,007)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,597,007)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?  n/a  If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning: 7/1/99

Ending:

6/30/00

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,934	2,080	\$ 46,592	\$ 22.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,801	12,689	245,312	19.33	3
4	Licensed Practical Nurses	3,102	3,336	54,489	16.33	4
5	Nurse Aides & Orderlies	54,131	58,205	613,567	10.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,211	2,389	52,742	22.08	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,228	2,396	32,136	13.41	10
11	Social Service Workers	2,902	3,120	41,673	13.36	11
12	Dietician					12
13	Food Service Supervisor	967	1,040	18,210	17.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,395	13,328	136,991	10.28	15
16	Dishwashers					16
17	Maintenance Workers	2,414	2,596	44,359	17.09	17
18	Housekeepers	10,867	11,685	89,274	7.64	18
19	Laundry	2,902	3,120	23,838	7.64	19
20	Administrator	2,306	2,479	65,341	26.36	20
21	Assistant Administrator					21
22	Other Administrative	6,296	6,770	125,910	18.60	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,760	11,569	154,898	13.39	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,904	6,348	63,242	9.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN/LPN Exception	1,190	1,280	23,560	18.41	33
34	TOTAL (lines 1 - 33)	134,310	144,430	\$ 1,832,134 *	\$ 12.69	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	163	\$ 7,341	1	35
36	Medical Director	Monthly	19,724	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	475	23,728	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Recreational Therapist</u>	664	19,935	11	46
47	<u>Psychologist</u>	78	6,596	10	47
48					48
49	TOTAL (lines 35 - 48)	1,380	\$ 77,324		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,960	36,204	10	52
53	TOTAL (lines 50 - 52)	1,960	\$ 36,204		53

Print Preview



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Assoc. \$1,497
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,595 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 136,772  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 15%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**Print Preview**

Marklund Deicke Home  
#0033074  
Fiscal Year 2000  
Schedule V. Cost Center Expenses

Line #27

\* Other includes: Fund-raising & Promotional 897006

Line #33 & Line #34  
Reclassification:

Real Estate Taxes reclassified from Rent-Facility 1619  
to Real Estate Taxes - based on Schedule XII. Rental Costs  
instructions related to Section A., question #2.

Marklund Deicke Home  
#0033074  
Fiscal Year 2000  
Schedule VI. Adjustment Detail

Line #29

Adjustment: Non-Allowable

Real Estate Taxes	2829
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Marklund Deicke Home  
#0033074  
Fiscal Year 2000  
Schedule XIX. Section C.  
Summary of Legal Services

Check #	Amount	Personnel	General Business
75438	60		60
75011	58	58	0
73996	17	17	
72938	68		68
73804	198	145	53
75806	2779		2779
76119	128		128
72409	8		8
73649	1268		1268
73282	769		769
74159	2645		2645
72929	269		269
Grand Total	8267	220	8047

Marklund Diecke Home  
Schedule XIX  
Seminars

Person Attending	Title	Date(s) of Seminar	Location	Sponsor/Title	Cost
Hilario Meneses	Support Services	08/23 thru 08/30/99	Gendale Heights, IL	Food Service Resource Group: Sanitation Certification	159
Barb Smorynski Lois Kramer Laurie Schaefer Melissa Capenigro Heather Fishbein Gloria Hudson	RN, BSN Director of Habilitation Music Therapist CTRS/ Resident Advocate CTRS Therapeutic Activity Aid	09/13 thru 09/15/99	Peoria, IL	Illinois Health Care Assc Illinois Health Care Assc Illinois Health Care Association: Anr	400
Jeanette Anderson	Administrative Assistant	10/28/99	Aurora, IL	Mistake Proof Grammar & Proofreading	99
Janet Franklin	Director of Support Services	05/05 thru 05/06/99	Rockford, IL	Rock River Valley District DMA: A New Millenium in Dietary Service	75
Janet Franklin	Director of Support Services	08/13 thru 08/17/99	Minneapolis, MN	Dietary Managers Association: DMA 40th Annual Meeting & Expo.	200
Barb Smorynski	Administrator, RN	05/31/00	Naperville, IL	Illinois Health Care Association: Nursing - Abuse and Neglect	80
Barb Smorynski	Administrator, RN	04/25/00	Naperville, IL	Illinois Health Care Association: Nursing - Dietary Connection	80
Judy Moore	RN	03/21/00	Carol Stream, IL	Midwest Medical/Legal Services	98
Barb Smorynski	Administrator, RN	April, 2000		Mass. Ext. Care Fed.: Care of the Medically Fragile Child in the New Millenium	250
Glenda Cosico	DON	03/22/00	River Grove, IL	Triton College: Basic ICD-9-CM Coding for LTC Personnel	75
Janet Franklin	Director of Support Services	10/01 thru 10/02/99	Matteson, IL	Northeastern District DMA: Illinois Dietary Managers Fall State Meeting	75
Glenda Cosico	DON	03/16/00	Glen Ellyn, IL	College of DuPage: Nursing CP Assesment	113
Lois Kramer	Director of Habilitation			Bethseda Lutheran Homes: Basic Management When You Are at the End of Your Rope How to Get People to Work Together Continuous Active Treatment	80
Jean Ruallo	RN	10/27 thru 10/29/99	Naperville, IL	American Association On Mental Retardation: IAAMR 1999 Annual Conference	45
Carol Saxon Barb Smorynski Margaret Walsh	LPN RN, BSN RN	03/21/00	Carol Stream, IL	Midwest Medical Legal Services: Documentation Through the Attorney's Eyes	196
Melissa Capenigro Heather Fishbein	CTRS/ Resident Advocate CTRS	05/01 thru 05/03/2000	Lake Geneva, WI	University of Missouri: Midwest Symposium on Therapeutic Recreation	335
Hilario Meneses Rafael Gallego	Support Services Support Services	April 1-8, June 5, 12	Naperville, IL	Paladin Management: Food Service Certification	537
Carol Saxon	LPN	02/17/00	Carol Stream, IL	College of DuPage: Nursing - Cardiac Distress	55
Barb Smorynski Glenda Cosico Heather Fishbein Janet Franklin	RN, BSN DON CTRS Director of Support Services	2/11, 2/25, 3/15, 3/18 , 05/24 thru 05/31/2000	Oak Brook, IL	College of DuPage Leadership Training	348
Jacqui LeBleu	Supervisor	03/14/00	Naperville	Arc of Illinois: Feya Koger - Self Determination	80
Dana Henke	OT	07/30/99	Rosemont, IL	University of Chicago: Spasticity in Cerebral Palsy - Current Treatment Techniques	110
Shannon Schleek Sharon Brown	Developmental Instructor Developmental Instructor	05/17/00	Springfield, IL	ICAN: Active Treatment	258
Total					3748

Marklund Diecke Home  
IDPA Cost Report  
Schedule XII  
Listing of Moveable Equipment

Description	Quantity
Minolta 4000 Copier	1
Minolta 3006 Fax Machine	1