



Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704 Report Period Beginning: 07/01/04 Ending: 06/30/05

**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	15,330	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	15,330	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	Private Pay	4 Other		
8	SNF					8
9	SNF/PED	14,425	545		14,970	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,425	545		14,970	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.65%

D. How many bed-hold days during this year were paid by the Department? 201 (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 03/18/04

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1988 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**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/05 Fiscal Year: 06/30/05

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

STATE OF ILLINOIS

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 07/01/04 Ending: 06/30/05

**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	146,961	8,418	9,951	165,330		165,330	165,330			1
2	Food Purchase		123,233		123,233		123,233	123,233			2
3	Housekeeping	53,904	18,796		72,700		72,700	72,700			3
4	Laundry	14,560	7,460		22,020		22,020	22,020			4
5	Heat and Other Utilities			57,237	57,237		57,237	57,237			5
6	Maintenance	17,358	9,303	30,189	56,850		56,850	56,850			6
7	Other (specify):*			9,778	9,778		9,778	9,778			7
8	<b>TOTAL General Services</b>	232,783	167,210	107,155	507,148		507,148	507,148			8
<b>B. Health Care and Programs</b>											
9	Medical Director			9,501	9,501		9,501	9,501			9
10	Nursing and Medical Records	1,164,862	117,002	273,687	1,555,551		1,555,551	1,555,551			10
10a	Therapy	80,584	501	10,000	91,085		91,085	91,085			10a
11	Activities	37,440	8,099	2,420	47,959		47,959	47,959			11
12	Social Services	15,808			15,808		15,808	15,808			12
13	CNA Training		75		75		75	75			13
14	Program Transportation	12,210			12,210		12,210	12,210			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,310,904	125,677	295,608	1,732,189		1,732,189	1,732,189			16
<b>C. General Administration</b>											
17	Administrative	55,016			55,016		55,016	55,016			17
18	Directors Fees										18
19	Professional Services			20,704	20,704		20,704	(13,233)	7,471		19
20	Dues, Fees, Subscriptions & Promotions			52,010	52,010		52,010	(13,470)	38,540		20
21	Clerical & General Office Expenses	163,369	56,224	35,104	254,697	(7,512)	247,185	247,185			21
22	Employee Benefits & Payroll Taxes			326,216	326,216		326,216	326,216			22
23	Inservice Training & Education										23
24	Travel and Seminar			4,224	4,224		4,224	4,224			24
25	Other Admin. Staff Transportation			10,985	10,985		10,985	10,985			25
26	Insurance-Prop.Liab.Malpractice			91,212	91,212		91,212	91,212			26
27	Other (specify):*			7,513	7,513		7,513	(7,513)			27
28	<b>TOTAL General Administration</b>	218,385	56,224	547,968	822,577	(7,512)	815,065	(34,216)	780,849		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,762,072	349,111	950,731	3,061,914	(7,512)	3,054,402	(34,216)	3,020,186		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 &amp; ID Number

Deicke Ctr-Marklund Chl Home

#0033704

Report Period Beginning:

07/01/04

Ending:

06/30/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			134,082	134,082		134,082	(37,655)	96,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,438	1,438		1,438	(1,438)				32
33	Real Estate Taxes			21	21		21	(21)				33
34	Rent-Facility & Grounds			33,000	33,000		33,000	(33,000)				34
35	Rent-Equipment & Vehicles					7,512	7,512		7,512			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			168,541	168,541	7,512	176,053	(72,114)	103,939			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			177,664	177,664		177,664		177,664			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			177,664	177,664		177,664		177,664			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,762,072	349,111	1,296,936	3,408,119		3,408,119	(106,330)	3,301,789			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 Deicke Ctr-Marklund Chl Home

# 0033704

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**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	1,438	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	13,470	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	13,233	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	5,000	27		24
25	Fund Raising, Advertising and Promotional	2,513	27		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	70,676			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 106,330		\$	30

OHF 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	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
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 106,330		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

Deicke Ctr-Marklund Chl Home

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Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	depreciation	\$ 37,655	30	1
2	real estate taxes	21	33	2
3	rent	33,000	34	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
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	<b>Total</b>	70,676		49

## STATE OF ILLINOIS

Summary A

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

# 0033704 Report Period Beginning:

07/01/04

Ending:

06/30/05

## 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)	
	<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>	<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>8</b>
	<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	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	<b>TOTAL Health Care and Programs</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>16</b>
	<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	13,233	0	0	0	0	0	0	0	0	0	0	13,233	19
20	Fees, Subscriptions & Promotions	13,470	0	0	0	0	0	0	0	0	0	0	13,470	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):*	7,513	0	0	0	0	0	0	0	0	0	0	7,513	27
28	<b>TOTAL General Administration</b>	<b>34,216</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>34,216</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>34,216</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>34,216</b>	<b>29</b>



Facility Name & ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning:

07/01/04

Ending:

06/30/05

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V		\$				\$	\$	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      Deicke Ctr-Marklund Chl Home      #      0033704      Report Period Beginning:      07/01/04      Ending:      06/30/05

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 07/01/04 Ending: 06/30/05

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 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	13,570,721	13,570,721	\$ 251	2,896,378	\$ 69	1	
2	2	Food	Direct Cost Budget	13,570,721	13,570,721	200	2,896,378	55	2	
3	3	Housekeeping	Direct Cost Budget	13,570,721	13,570,721	4,959	2,896,378	1,368	3	
4	5	Utilities	Direct Cost Budget	13,570,721	13,570,721	43,811	2,896,378	12,088	4	
5	6	Maintenance	Direct Cost Budget	13,570,721	13,570,721	20,979	2,896,378	5,788	5	
6	7	Disposal	Direct Cost Budget	13,570,721	13,570,721	16,337	2,896,378	4,507	6	
7	13	BNATP	Direct Cost Budget	13,570,721	13,570,721	271	2,896,378	75	7	
8	14	Transportation	Direct Cost Budget	13,570,721	13,570,721	0	2,896,378	0	8	
9	19	Professional Services	Direct Cost Budget	13,570,721	13,570,721	27,078	2,896,378	7,471	9	
10	20	Fees, Subscription	Direct Cost Budget	13,570,721	13,570,721	131,150	2,896,378	36,185	10	
11	21	Clerical/Office	Direct Cost Budget	13,570,721	13,570,721	592,204	407,000	2,896,378	170,971	11
12	22	Benefits	Direct Cost Budget	13,570,721	13,570,721	53,082	2,896,378	8,847	12	
13	24	Travel & Seminars	Direct Cost Budget	13,570,721	13,570,721	9,791	2,896,378	2,701	13	
14	25	Staff Transportation	Direct Cost Budget	13,570,721	13,570,721	17,902	2,896,378	4,939	14	
15	26	Insurance	Direct Cost Budget	13,570,721	13,570,721	11,262	2,896,378	3,107	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 929,277	\$ 407,000	\$ 258,171	25	

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

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

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2004 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 2005 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	N/A	8	
		2001		9	
		2002		10	
		2003		11	
		2004		12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2004	\$			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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Deicke Ctr-Marklund Chl Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0033704

CONTACT PERSON REGARDING THIS REPORT Lisa Custardo

TELEPHONE (630) 593-5500 FAX #: (630) 593-5481

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-13-100-001,002,003</u>	<u>Residential - Tax Exempt</u>	<u>\$ None</u>	<u>\$ None</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ _____</b>	<b>\$ _____</b>

**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? N/A YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, attach an explanation & 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 a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Deicke Ctr-Marklund Chl Home# 0033704 Report Period Beginning:07/01/04 Ending:06/30/05

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,250 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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	Apr-88	\$ 100,000	1
2					2
3	TOTALS	110,816		\$ 100,000	3

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

# 0033704

Report Period Beginning:

07/01/04

Ending:

06/30/05

**XL 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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1988	1964	\$ 669,211	\$ 33,461	20	\$ 33,461	\$	\$ 585,560	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Replacement of circular drive - Land impr.		1990	1,725		5			1,725	9
10	black top work on driveway - Land Impr.		1992	2,484		5			2,484	10
11	resurfacing of parking lot - Land impr.		1993	810		5			810	11
12	removal/replacement of sidewalk - Land impr.		1994	600		5			600	12
13	stone bed work - Land impr.		1995	2,490		5			2,490	13
14	tree trimming/landscaping - Land impr		1996	3,055		5			3,055	14
15	pavement,asphalt - Land impr.		1996	15,000		5			15,000	15
16	Concrete Work - Land impr.		1999	6,460		5			6,460	16
17	Landscaping Land impr.		2000	1,236	124	5	124		1,236	17
18	Nature Trail - Land impr.		2000	2,100	210	5	210		2,100	18
19	Replace Parking Lot/Asphalt - Land impr.		2000	5,566		5			5,566	19
20	Repair and Resurface Driveway - Land impr.		2000	24,907	4,981	5	4,981		22,416	20
21	Brick Patio		2003	6,025	1,205	5	1,205		1,808	21
22	Seal Coat/Striping parking-lot		2003	3,497	1,748	2	1,748		2,623	22
23	Security system		1988	2,055		10			2,055	23
24	renovations		1989	230,082	11,504	20	11,504		189,818	24
25	exterior canopy		1990	4,303	215	20	215		3,120	25
26	signage		1990	1,803		10			1,803	26
27	canopy sprinkler		1990	1,148		10			1,148	27
28	exterior staining		1991	2,650		5			2,650	28
29	storage shed		1992	899		5			899	29
30	windows		1993	5,838		10			5,838	30
31	retile tubs		1993	2,000		5			2,000	31
32	ac repair/renovation		1993	547		5			547	32
33	roof repair		1993	2,150		5			2,150	33
34	kitchen floor		1993	5,000		5			5,000	34
35	gutters, downspouts, soffit		1994	5,900	295	10	295		5,900	35
36	master key system		1994	607		5			607	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 &amp; ID Number Deicke Ctr-Marklund Chl Home

# 0033704

Report Period Beginning:

07/01/04

Ending:

06/30/05

## 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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Tiling kitchen walls	1995	\$ 1,400	\$	5	\$	\$ 1,400		37
38	Water heater	1995	3,765	188	5	188		3,765	38
39	Anti-Freeze Loop system for Fire Protection	1999	2,532	101	25	101		658	39
40	Painting	1999	4,250		5			4,250	40
41	Water Heater	1998	4,450		5			4,450	41
42	Floor repair	1997	1,220	137	10	137		1,022	42
43	New Water Closet	1999	732	73	10	73		476	43
44	vestibule addition	1999	42,700	4,270	15	4,270		27,755	44
45	exhaust fan	1999	2,000	133	5	133		867	45
46	siding	1999	2,135		25			2,135	46
47	fire alarm fitting	1999	312	12	10	12		81	47
48	auto doors new enclosure	1999	11,547	1,155	5	1,155		7,506	48
49	flooring new entrance	1999	1,383		5			1,383	49
50	painting & renovation	1999	2,650		5			2,650	50
51	air curtain	1999	767		5			767	51
52	air curtain	1999	934		5			934	52
53	flooring/carpeting	1999	42,747		15			42,747	53
54	soffits/ceiling/plumbing upgrades	1999	72,156	5,385	10	5,385		35,003	54
55	Electric sliding door	2000	1,322	264	5	264		1,190	55
56	New Tile Flooring	2002	1,398	280	5	280		979	56
57	Hot Water Heater	2001	3,500	233	15	233		817	57
58	Generator	2001	2,345	469	5	469		1,642	58
59	Six windows replaced	2003	3,030	606	5	606		909	59
60	Venilation system upgrade	2004	3,244	649	5	649		973	60
61	Parking lot asphalt repairs, sealcoating, striping	2005	6,713	1,678	2	1,678		1,678	61
62	Fireproof door with latch	2005	2,883	288	5	288		288	62
63	Exterior door with lock	2005	972	97	5	97		97	63
64	Replacement of air handling equipment	2005	659	66	5	66		66	64
65	HVAC replacement	2005	14,679	734	10	734		734	65
66	Electrical Generator	2005	86,793	8,679	5	8,679		8,679	66
67	Remodeling 2 bathrooms and entrance	2005	10,999	1,100	5	1,100		1,100	67
68	Fire-rated interior door	2005	2,146	215	5	215		215	68
69	6 vinyl replacement windows	2005	3,000	300	5	300		300	69
70	TOTAL (lines 4 thru 69)		\$ 1,351,511	\$ 80,857		\$ 80,857	\$	\$ 1,034,980	70

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	
71	Purchased in Prior Years	\$ 134,204	\$ 9,875	\$ 9,875			\$ 99,068	71
72	Current Year Purchases	28,422	2,294	2,294	(0)	8	2,294	72
73	Fully Depreciated Assets	201,072					201,072	73
74								74
75	TOTALS	\$ 363,698	\$ 12,169	\$ 12,169	\$ (0)		\$ 302,434	75

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	
76	Maintenance	2004 Ford F-250	2004	\$ 17,005	\$ 3,401	\$ 3,401		5	\$ 5,102	76
77	General Use	1996 Ford 4x4	1996	20,537				5	20,537	77
78	Patient Transport	1999 Bluebird Bus	1998	73,186				5	73,186	78
79										79
80	TOTALS			\$ 110,728	\$ 3,401	\$ 3,401			\$ 98,825	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)	\$ 1,925,936	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,427	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,427	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,436,239	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

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

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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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: \$ 7,512 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	<b>TOTAL</b>		\$	\$	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.

**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.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input 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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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													12
13	Other (specify):													13
14	<b>TOTAL</b>			\$		\$		\$		\$		\$		14

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

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

# 0033704

Report Period Beginning: 07/01/04

Ending:

06/30/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/05

(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	\$ 1,157,619	\$ 1,157,619	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 11,400 )	2,529,348	2,529,348	3
4 Supply Inventory (priced at Cost )	40,240	40,240	4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	59,187	59,187	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Client Related Accounts	601,779	601,779	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,388,173	\$ 4,388,173	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	6,168,624	6,168,624	13
14 Buildings, at Historical Cost	20,049,202	20,049,202	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	4,576,555	4,576,555	16
17 Accumulated Depreciation (book methods)	(9,210,455)	(9,210,455)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	7,083,881	7,083,881	21
22 Other Long-Term Assets (spe Limited or Restricted)	2,063,846	2,063,846	22
23 Other(specify): Construction in Progress	746,266	746,266	23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 31,477,919	\$ 31,477,919	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 35,866,092	\$ 35,866,092	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 200,301	\$ 200,301	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	268,834	268,834	30
31 Accrued Taxes Payable (excluding real estate taxes)	21,507	21,507	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 <b>Other-compensation and related payables</b>	1,235,556	1,235,556	36
37 <b>Misc. Other</b>	2,688,761	2,688,761	37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,414,959	\$ 4,414,959	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>	\$ 4,414,959	\$ 4,414,959	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 31,451,133	\$ 31,451,133	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 35,866,092	\$ 35,866,092	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>31,328,701</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>31,328,701</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(232,589)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	1,202,120	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Remaining Consolidated Inc/(Loss)</b>	(1,080,850)	<b>15</b>
<b>16</b>	Other (describe) <b>Change in Unrealized Gains/(Losses)</b>	303,450	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>192,131</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfer out of Restricted Funds in to Operations-Expenses</b>	(69,699)	<b>18</b>
<b>19</b>	<b>Transfer out of Restricted Funds in to Operations-Capital</b>	(987,530)	<b>19</b>
<b>20</b>	<b>Transfer into Operations from Restricted Funds-Capital</b>	987,530	<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(69,699)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>31,451,133</b>	<b>24</b> *

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

**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	\$ 2,920,120	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,920,120</b>	<b>3</b>
<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>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	149,080	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 149,080</b>	<b>26</b>
<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>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,069,200</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	507,148	31
32	Health Care	1,732,189	32
33	General Administration	780,849	33
<b>B. Capital Expense</b>			
34	Ownership	103,939	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	177,664	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,301,789</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(232,589)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (232,589)</b>	<b>43</b>

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

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

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

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

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

# 0033704

Report Period Beginning: 07/01/04

Ending:

06/30/05

## 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	1,976	2,080	\$ 78,520	\$ 37.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,500	17,368	408,827	23.54	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	51,376	54,080	574,805	10.63	5
6	CNA Trainees					6
7	Licensed Therapist	3,063	3,224	70,681	21.92	7
8	Rehab/Therapy Aides	593	624	9,903	15.87	8
9	Activity Director					9
10	Activity Assistants	2,964	3,120	37,440	12.00	10
11	Social Service Workers	790	832	15,808	19.00	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	41,662	20.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,453	11,003	98,746	8.97	15
16	Dishwashers	889	936	6,552	7.00	16
17	Maintenance Workers	988	1,040	17,358	16.69	17
18	Housekeepers	6,264	6,594	53,904	8.17	18
19	Laundry	1,976	2,080	14,560	7.00	19
20	Administrator	1,976	2,080	55,016	26.45	20
21	Assistant Administrator					21
22	Other Administrative	5,849	6,157	119,873	19.47	22
23	Office Manager	1,976	2,080	36,195	17.40	23
24	Clerical	395	416	7,301	17.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,928	6,240	95,846	15.36	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	593	624	6,864	11.00	31
32	Other Health Care(specify)	988	1,040	12,210	11.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,513	123,698	\$ 1,762,071 *	\$ 14.24	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	192	\$ 9,496	1	35
36	Medical Director	Monthly	9,501	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	1,796	10,000	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	23	1,976	10a	46
47	Vision	Monthly	2,488	10	47
48					48
49	TOTAL (lines 35 - 48)	2,011	\$ 33,461		49

## C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,238	\$ 245,375	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	9,509	23,848	10	52
53	TOTAL (lines 50 - 52)	14,746	\$ 269,223		53





Facility Name & ID Number Deicke Ctr-Marklund Chl Home# 0033704Report Period Beginning: 07/01/04Ending: 06/30/05**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Healthcare Association - \$1,999
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,185 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 177,664  
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? Yes, Sch.8 If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Cost Report  
Seminars  
FY 05

Marklund Deicke

6015796

Date of Seminar	Company Providing Seminar	Persons Attending	Job Title	Cost of Seminar
8/16/2004	Illinois Healthcare Association- Annual /Conference	Laurie Schaefer	QMRP	\$ 54.55
		Chester Guzman	Theraputic Activity Aide	54.55
09/18/04	Central DuPage Hospital - CPR Instructor Course	Marjorie Gross	RN	140.00
11/4/2004	Triton College- Seminar-Social Services-LTC Trainin	Jessica O'Neill	Social Services Manager	72.00
11/11/04	Lana Bamert - CPR Class	April Smith	CAN	25.00
		Laurie Colles	RN-DON	25.00
		Kevin O'Brien	RN	25.00
		Riel Vergara	RN	25.00
11/17/2004	Rockhurst Univ- Seminar- Philosophy at Work	Nancy Rodriguez	Administrator / MDH	199.00
2/15/2005	The Institute-Seminar- Pressure Ulcers	Nancy Rodriguez	Administrator / MDH	104.25
02/05/05	Diana Book-Sanitation Class	Laura Gomez	Dietary Aide	50.00
03/10/05	Central II DDNA-Seminar Developmental Disabilities	Laurie Colles	RN- DON	100.00
03/11/05	Fred Pryor Seminars/Careertrack - Stress Mgmt	Jeanette Anderson	Adm. Asst. / MDH	39.00
		Nancy Rodriguez	Administrator / MDH	39.00
03/15/05	Laurie Colles- hotel room DDNA Seminar	Laurie Colles	Director of Nursing	131.09
4/7/2005	Enviromental Training Consultants	Mike Ronnerberg	Maintenance	238.86
6/1/2005	Culture Training	Randy Cooper	Administrator / MDH	199.70
8/10/2004	Illinois State Council- SHRM Conference	Joan Rubino	Director of Human Resources	73.62
		Lissy Rivera	Employment & Benefit Coord.	73.62
8/16/2004	Illinois Healthcare Association- Annual /Conference	Diana Book	Director of Support Services	19.03
9/8/2004	Waubonsee Community College- Excel Class	Becky Dahm	Accounts Payable Clerk	36.70
9/15/2004	Padgett Thompson- Conference/Workshop	Sarah Jensen	Adm. Asst. / CEO Joel	68.61
		Peggy Szarynski	Adm. Asst. / H/R	68.61
9/30/2004	Voice of the Retarded - Annual Dues	Joel Rusco	President/CEO	133.38
9/30/2004	AICPA-Membership	Lisa Custardo	Executive Director	36.11
10/15/04	American Red Cross - CPR & 1st Aid Class	Alice Morgan	LPN	62.95
10/28/2004	Business 21- Phone Conference- EEOC Charges &	Joan Rubino	Director of Human Resources	21.23
		Lissy Riviera	Employment & Benefit Coord.	21.23
11/17/2004	Rockhurst Univ- Seminar- Philosophy at Work	Joan Rubino	Director of Human Resources	4.90
4/7/2005	Enviromental Training Consultants	Mike Ronnerberg	Maintenance	2.37
06/01/05	Culture Training	Lisa Custardo	Executive Director	188.97
		Joel Rusco	President/CEO	188.97
		Joan Rubino	Director of Human Resources	188.97
		Wendy Berk	Administrator	188.97
		Nancy Rodriguez	Director of Adult Services	188.97
		Terry Arya	VP of Development	188.97
		Kudus Badmus	Director of Finance	188.97
		Lois Kramer	Director of Children's Services	188.97
		Randy Cooper	Administrator	188.97
		Cindy Hillsabeck	Administrator	188.97
		Jeannine Zupo	Director of PR/Marketing	188.97
				<hr/>
				\$ 4,223

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	DI 450	1
Fax	Minolta	1800	1
Copier	Minolta	1030	1