

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0045575

**Facility Name:** Marklund Sayers Home

**Address:** 1 South 383 Wyatt Drive Geneva 60134  
 Number City Zip Code

**County:** Kane

**Telephone Number:** (630) 593-5500 **Fax #** (630)593-5481

**HFS ID Number:** 36-2652532005

**Date of Initial License for Current Owners:** 08/25/03

**Type of Ownership:**

<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	

**In the event there are further questions about this report, please contact:**  
**Name:** Lisa Custardo **Telephone Number:** (630) 593-5479

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Joel Rusco</u>	
	(Title) <u>President/CEO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Marklund Sayers Home

# 0045575 Report Period Beginning: 07/01/05 Ending: 06/30/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,091</u>	<u>730</u>	<u>0</u>	<u>5,821</u>	13
14	TOTALS	<u>5,091</u>	<u>730</u>		<u>5,821</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.67%

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

19 (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 08/25/03

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/05 Ending: 06/30/06

**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	32,703	1,535	2,611	36,849		36,849	36,849			1
2	Food Purchase		38,191		38,191		38,191	38,191			2
3	Housekeeping	17,160	6,576	22	23,758		23,758	23,758			3
4	Laundry	13,656	3,174		16,830		16,830	16,830			4
5	Heat and Other Utilities			29,474	29,474		29,474	29,474			5
6	Maintenance	21,038	3,046	12,679	36,763		36,763	36,763			6
7	Other (specify):* <b>Disposal Service</b>			2,265	2,265		2,265	2,265			7
8	<b>TOTAL General Services</b>	<b>84,557</b>	<b>52,522</b>	<b>47,051</b>	<b>184,130</b>		<b>184,130</b>	<b>184,130</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,888	3,888		3,888	3,888			9
10	Nursing and Medical Records	578,001	31,440	112,768	722,209		722,209	722,209			10
10a	Therapy	27,019	945	3,543	31,507		31,507	31,507			10a
11	Activities	12,480	6,764		19,244		19,244	19,244			11
12	Social Services	2,496			2,496		2,496	2,496			12
13	CNA Training		48		48		48	48			13
14	Program Transportation	12,480		8,117	20,597		20,597	20,597			14
15	Other (specify):* <b>Vision, Dental, Pharmacy, Psychologist Consultants</b>			1,040	1,040		1,040	1,040			15
16	<b>TOTAL Health Care and Programs</b>	<b>632,476</b>	<b>39,197</b>	<b>129,356</b>	<b>801,029</b>		<b>801,029</b>	<b>801,029</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	48,363			48,363		48,363	48,363			17
18	Directors Fees										18
19	Professional Services			8,094	8,094		8,094	(4,339)	3,755		19
20	Dues, Fees, Subscriptions & Promotions			13,127	13,127		13,127	(2,893)	10,234		20
21	Clerical & General Office Expenses	54,437	20,221	6,552	81,210	(2,328)	78,882		78,882		21
22	Employee Benefits & Payroll Taxes			138,060	138,060		138,060		138,060		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,136	2,136		2,136		2,136		24
25	Other Admin. Staff Transportation			1,514	1,514		1,514		1,514		25
26	Insurance-Prop.Liab.Malpractice			22,525	22,525		22,525		22,525		26
27	Other (specify):* <b>Fund-Raising/Promotional</b>			1,367	1,367		1,367	(1,367)			27
28	<b>TOTAL General Administration</b>	<b>102,800</b>	<b>20,221</b>	<b>193,375</b>	<b>316,396</b>	<b>(2,328)</b>	<b>314,068</b>	<b>(8,599)</b>	<b>305,469</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>819,833</b>	<b>111,940</b>	<b>369,782</b>	<b>1,301,555</b>	<b>(2,328)</b>	<b>1,299,227</b>	<b>(8,599)</b>	<b>1,290,628</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Sayers Home #0045575 Report Period Beginning: 07/01/05 Ending: 06/30/06

## 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			98,263	98,263		98,263	(12,177)	86,086			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			169	169		169	(169)				32
33	Real Estate Taxes			7	7		7	(7)				33
34	Rent-Facility & Grounds			6,616	6,616		6,616	(6,616)				34
35	Rent-Equipment & Vehicles					2,328	2,328		2,328			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			105,055	105,055	2,328	107,383	(18,969)	88,414			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			75,723	75,723		75,723		75,723			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			75,723	75,723		75,723		75,723			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	819,833	111,940	550,560	1,482,333		1,482,333	(27,568)	1,454,765			45

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

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05

Ending:

06/30/06

**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	(169)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,893)	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	(4,339)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,250)	27		24
25	Fund Raising, Advertising and Promotional	(117)	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	(18,800)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (27,568)		\$	30

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>	\$ (27,568)		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

BHF USE ONLY						
48		49		50		51
						52

Marklund Sayers Home

ID# 0045575

Report Period Beginning: 07/01/05

Ending: 06/30/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	depreciation	\$ (12,177)	30	1
2	real estate taxes	(7)	33	2
3	rent	(6,616)	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>	(18,800)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05

Ending:

06/30/06

## 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>	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	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>	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	(4,339)	0	0	0	0	0	0	0	0	0	0	(4,339)	19
20	Fees, Subscriptions & Promotions	(2,893)	0	0	0	0	0	0	0	0	0	0	(2,893)	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):*	(1,367)	0	0	0	0	0	0	0	0	0	0	(1,367)	27
28	<b>TOTAL General Administration</b>	(8,599)	0	0	0	0	0	0	0	0	0	0	(8,599)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(8,599)	0	0	0	0	0	0	0	0	0	0	(8,599)	29

STATE OF ILLINOIS

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05 Ending:

Summary B

06/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,177)	0	0	0	0	0	0	0	0	0	0	(12,177)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(169)	0	0	0	0	0	0	0	0	0	0	(169)	32
33	Real Estate Taxes	(7)	0	0	0	0	0	0	0	0	0	0	(7)	33
34	Rent-Facility & Grounds	(6,616)	0	0	0	0	0	0	0	0	0	0	(6,616)	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>(18,969)</b>	<b>0</b>	<b>(18,969)</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</b> (sum of lines 29, 37 & 44)	<b>(27,568)</b>	<b>0</b>	<b>(27,568)</b>	<b>45</b>									

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05

Ending:

06/30/06

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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 Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/05 Ending: 06/30/06

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	1	Dietary	Direct Cost Budget	13,331,980	13331980	\$ 793	\$	1,112,482	\$ 66	1
2	2	Food	Direct Cost Budget	13,331,980	13331980	216		1,112,482	18	2
3	3	Housekeeping	Direct Cost Budget	13,331,980	13331980	6,126		1,112,482	511	3
4	5	Utilities	Direct Cost Budget	13,331,980	13331980	50,989		1,112,482	4,255	4
5	6	Maintenance	Direct Cost Budget	13,331,980	13331980	17,583		1,112,482	1,467	5
6	7	Disposal	Direct Cost Budget	13,331,980	13331980	10,389		1,112,482	867	6
7	13	BNATP	Direct Cost Budget	13,331,980	13331980	580		1,112,482	48	7
8	14	Transportation	Direct Cost Budget	13,331,980	13331980	6,769		1,112,482	565	8
9	19	Professional Services	Direct Cost Budget	13,331,980	13331980	45,000		1,112,482	3,755	9
10	20	Fees, Subscription	Direct Cost Budget	13,331,980	13331980	111,700		1,112,482	9,321	10
11	21	Clerical/Office	Direct Cost Budget	13,331,980	13331980	957,057	726,738	1,112,482	79,861	11
12	22	Benefits	Direct Cost Budget	13,331,980	13331980	122,383		1,112,482	10,212	12
13	24	Travel & Seminars	Direct Cost Budget	13,331,980	13331980	15,941		1,112,482	1,330	13
14	25	Staff Transportation	Direct Cost Budget	13,331,980	13331980	14,295		1,112,482	1,193	14
15	26	Insurance	Direct Cost Budget	13,331,980	13331980	14,457		1,112,482	1,206	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,374,278	\$ 726,738		\$ 114,675	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

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 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:				
2001	<u>N/A</u>	8		
2002		9		
2003		10		
2004		11		
2005		12		
			<b>FOR BHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Marklund Sayers Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045575

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 2005 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 2005.

(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>11-24-100-029</u>	<u>Residential - Tax Exempt</u>	<u>\$ None</u>	<u>\$ None</u>
2. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
<b>TOTALS</b>		<u>\$ _____</u>	<u>\$ _____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Marklund Sayers Home

# 0045575 Report Period Beginning:

07/01/05 Ending:

06/30/06

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Marklund Hyde Center Day Training 43,000 Square Feet 100 Person Capacity

Marklund Haverkamp Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity

Marklund Vandermolen Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity

Marklund Tommy Home 16-Bed Facility 8,315 Square Feet 16 Person Capacity

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	<u>Long Term Care</u>	<u>67,518</u>	<u>1999</u>	<u>\$ 318,871</u>	1
2					2
3	<b>TOTALS</b>	<b>67,518</b>		<b>\$ 318,871</b>	<b>3</b>

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05

Ending:

06/30/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264		\$ 153,159	4
5			2003	2003	76,537	7,654	10	7,654		19,134	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Electrical Upgrade		2003	3,199	689	5	689		1,475	9
10		Gutter Installation		2004	383	77	5	77		192	10
11		Emergency battery lights - generator		2005	333	33	10	33		50	11
12		Sealcoating of driveway and paths		2005	1,712	856	2	856		1,284	12
13		Grading and seeding of land parcel		2005	301	60	5	60		90	13
14		Bollard Lighting		2005	1,300	260	5	260		390	14
15		Concrete slabs by dumpsters		2006	1,950	195	5	195		195	15
16		Custom exterior signage		2006	1,227	123	5	123		123	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning:

07/01/05

Ending:

06/30/06

**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,312,214	\$ 71,210		\$ 71,210	\$	\$ 176,092	70

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

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/05 Ending: 06/30/06

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	\$ 73,488	\$ 12,859	\$ 12,859	\$		\$ 31,129	71
72	Current Year Purchases	6,053	605	605			605	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 79,541	\$ 13,464	\$ 13,464	\$		\$ 31,734	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	Outings / Appointments	1999 Bluebird Bus (1/4)	1999	\$ 18,297	\$	\$	\$	5	\$ 18,297	76
77	Maintenance	2003 Ford F-250 (1/4)	2003	7,060	1,412	1,412			4,942	77
78	Lifts/ Straps	Lifts/ Straps	1999	4,140					4,140	78
79										79
80	TOTALS			\$ 29,497	\$ 1,412	\$ 1,412	\$		\$ 27,379	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)		\$ 1,740,123	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 86,086	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 86,086	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 235,205	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning: 07/01/05

Ending: 06/30/06

**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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 2,328      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		3	4
		1	2		
		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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	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									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 & ID Number Marklund Sayers Home# 0045575Report Period Beginning: 07/01/05

Ending:

06/30/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 789,667	\$ 789,667	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>126,500</u> )	2,432,458	2,432,458	3
4	Supply Inventory (priced at )	45,440	45,440	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	83,717	83,717	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Client Related Accounts</u>	618,152	618,152	9
	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,969,434	\$ 3,969,434	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,404,557	6,404,557	13
14	Buildings, at Historical Cost	22,538,172	22,538,172	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,686,251	4,686,251	16
17	Accumulated Depreciation (book methods)	(10,420,208)	(10,420,208)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,499,757	6,499,757	21
22	Other Long-Term Assets (specify):	1,962,880	1,962,880	22
23	Other(specify): <u>Construction in Progress</u>	28,041	28,041	23
	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 31,699,450	\$ 31,699,450	24
	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 35,668,884	\$ 35,668,884	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 364,940	\$ 364,940	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	286,117	286,117	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,127	17,127	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>Other: Compensation &amp; Related Payables</u>	1,050,832	1,050,832	36
37	<u>Misc. Other</u>	2,781,984	2,781,984	37
	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,501,000	\$ 4,501,000	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
	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,501,000	\$ 4,501,000	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 31,167,884	\$ 31,167,884	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 35,668,884	\$ 35,668,884	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,451,133	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,451,133	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(128,395)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,160,502	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Remaining Cosolidated Income (loss)</u>	(1,342,840)	15
16	Other (describe) <u>Change in Unrealized Gains (losses)</u>	166,304	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (144,429)	17
<b>B. Transfers (Itemize):</b>			
18	<u>Transfer out of Restrcted Funds into Operations - Exp</u>	(138,820)	18
19	<u>Transfer out of Restricted Funds into Operations-Capital</u>	(1,771,445)	19
20	<u>Transfer into Operations from Restricted Funds</u>	1,771,445	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (138,820)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,167,884	24 *

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

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning: 07/01/05

Ending: 06/30/06

**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	\$ 1,304,678	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,304,678	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	CNA Training Reimbursements	1,800	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>	\$ 1,800	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	19,892	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 19,892	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>	\$ 1,326,370	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	184,130	31
32	Health Care	801,029	32
33	General Administration	305,469	33
<b>B. Capital Expense</b>			
34	Ownership	88,414	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	75,723	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,454,765	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(128,395)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (128,395)	43

\* 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 & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning: 07/01/05

Ending:

06/30/06

**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	494	520	\$ 16,853	\$ 32.41	1
2	Assistant Director of Nursing	1,976	2,080	52,000	25.00	2
3	Registered Nurses	5,295	5,574	139,126	24.96	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	25,984	27,352	333,678	12.20	5
6	CNA Trainees					6
7	Licensed Therapist	849	894	21,403	23.94	7
8	Rehab/Therapy Aides	395	416	5,616	13.50	8
9	Activity Director					9
10	Activity Assistants	988	1,040	12,480	12.00	10
11	Social Service Workers	198	208	2,496	12.00	11
12	Dietician					12
13	Food Service Supervisor	494	520	11,586	22.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,976	2,080	17,368	8.35	15
16	Dishwashers	494	520	3,749	7.21	16
17	Maintenance Workers	1,087	1,144	21,038	18.39	17
18	Housekeepers	1,976	2,080	17,160	8.25	18
19	Laundry	1,640	1,726	13,656	7.91	19
20	Administrator	1,186	1,248	48,363	38.75	20
21	Assistant Administrator					21
22	Other Administrative	2,351	2,475	49,638	20.06	22
23	Office Manager					23
24	Clerical	316	333	4,799	14.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	33,280	16.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	257	270	3,064	11.35	31
32	Other Health Care <u>Transportation</u>	988	1,040	12,480	12.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	50,920	53,600	\$ 819,833 *	\$ 15.30	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	36	\$ 1,784	1	35
36	Medical Director	Monthly	3,888	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	263	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	60	10a	42
43	Speech Therapy Consultant	50	3,483	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	6	510	15	46
47	<u>Vision</u>	13	267	15	47
48					48
49	TOTAL (lines 35 - 48)	107	\$ 10,255		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,883	\$ 84,559	10	50
51	Licensed Practical Nurses	125	4,198	10	51
52	Certified Nurse Assistants/Aides	998	24,011	10	52
53	TOTAL (lines 50 - 52)	3,006	\$ 112,768		53

Facility Name & ID Number Marklund Sayers Home

# 0045575

Report Period Beginning: 07/01/05

Ending: 06/30/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Jessica O'Neall			\$ 54,437	Workers' Compensation Insurance	\$ 14,427	IDPH License Fee	\$		
				Unemployment Compensation Insurance	3,829	Advertising: Employee Recruitment	8,775		
				FICA Taxes	62,717	Health Care Worker Background Check			
				Employee Health Insurance	38,384	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		IHCA DUES	839		
				Pension	14,565	Misc. Dues/Subscriptions	620		
				Dental	3,678				
				Life Insurance/Disability	460				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 54,437	TOTAL (agree to Schedule V, line 22, col.8)			\$ 138,060		
(List each licensed administrator separately.)				TOTAL (agree to Sch. V, line 20, col. 8)			\$ 10,234		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	2,136	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,136
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
KPMG	audit fees	\$ 3,755							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,755						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Marklund Sayers Home

**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 -\$839
- (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 year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,826 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. \$ 75,723  
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.

DATE OF SEMINAR	COMPANY PROVIDING SEMINAR	PERSONS ATTENDING	JOB TITLE	COST OF SEMINAR
09/22/05	Another Answer Seminar/Difficult People	Wendy Berk	Administrator	\$ 37.25
10/17/05	Fred Pryor Seminars/Defuse Anger	Wendy Berk	Administrator	47.25
10/17/05	Fred Pryor Seminars/Defuse Anger	Nancy Rodriguez	Administrator	37.80
10/17/05	Fred Pryor Seminars/Defuse Anger	Diana Book	Director Support Services	37.80
11/15/05	Collaborative Healthcare Urgency Group	Diana Book	Director Support Services	8.33
11/15/05	Collaborative Healthcare Urgency Group	Kerry Berg	Maintenance Technician	8.34
11/08/05	Rehab Connections/Aquatic Workshop	Meggin Bundy	Therapy Aide	50.00
01/25/06	Skill Path/Teambuilding Conference	Wendy Berk	Administrator	49.75
01/25/06	Skill Path/Teambuilding Conference	Nancy Rodriguez	Director of Adult Services	39.80
01/31/06	Riatt Nasdse/Assessment Gathering	Joanna Vicker	Certified Occupational Therapy Assistant	44.29
01/31/06	Riatt Nasdse/Assessment Gathering	Joanna Vicker	Certified Occupational Therapy Assistant	44.30
02/17/06	Northwestern/Up and Walking	Rose Vicker	Physical Therapy Assistant	22.86
02/07/06	Oakton CC/Theory to Practice	Rose Vicker	Physical Therapy Assistant	31.77
03/31/06	Sunrise Medical/Mobility Power	Joanna Vicker	Assistive Tech Coordinator	6.67
03/31/06	Sunrise Medical/Mobility Power	Jalpa Panda	Director of Therapy Services	6.67
03/31/06	Illinois Health Care/Therapeutic Activities	Maria Anda	Therapeutic Activity Aid	42.50
04/30/06	Inst Public Policy/Beyond Meds/Restraint/Isoltn	Wendy Berk	Administrator	114.56
04/13/06	DDNA Conf/Education & Development	Laurie Colles	RN-DON	81.80
04/26/06	E-Clips/Hair Instruction	Vicki Reyes	Certified Occupational Therapy Assistant	11.25
04/30/06	Fred Pryor/Reading Dynamics	Wendy Berk	Administrator	37.25
06/30/06	The Institute/Teleconference	Nancy Rodriguez	Director of Adult Services	19.75
06/30/06	Cross Country Ed/Leadership & Mgmt	Jalpa Pandya	Director of Therapy Services	25.57
07/01/05	Central DuPage Hospital- CPR Cards	Joan Rubino	Director Human Resources	9.61
09/09/05	Illinois Healthcare/55th Convention	Diana Book	Director Support Services	13.14
09/15/05	Wessles & Pautsch-Tackling HR Issues	Joan Rubino	Director Human Resources	6.26
09/15/05	Wessles & Pautsch-Tackling HR Issues	Lissy Rivera	Employee Benefits Coordinator	6.26
09/28/05	Illinois Public Health - Food Safety	Diana Book	Director Support Services	6.26
10/17/05	Fred Pryor Seminars/Defuse Anger	Lisa Custardo	Executive Director	15.77
10/17/05	Fred Pryor Seminars/Defuse Anger	Joan Rubino	Director Human Resources	15.77
10/26/05	Rockhurst Univ-Cutting Edge Assistant	Peggy Szarzynski	Administrative Assistant	8.30
10/26/05	Rockhurst Univ-Cutting Edge Assistant	Sarah Jensen	Administrative Assistant	8.30
11/15/05	Collaborative Healthcare Urgency Group	Diana Book	Director Support Services	0.70
11/15/05	Collaborative Healthcare Urgency Group	Kerry Berg	Maintenance Technician	0.70
02/28/06	Fred Pryor/Excel	Peggy Szarzynski	Administrative Assistant	10.68
03/08/06	Dietary Mgrs Assoc/Ceu Book	Diana Book	Director Support Services	5.42
03/13/06	Business Publications/Performance Reviews	Joan Rubino	Director Human Resources	24.95
03/31/06	Wessels & Pautsch/Job Descriptions	Peggy Szarzynski	Administrative Assistant	2.09
03/31/06	Wessels & Pautsch/Job Descriptions	Joan Rubino	Director Human Resources	2.09
05/15/06	Nursing Spectrum/Career Fair	Lizzy Rivera	Employment & Benefits Coordinator	2.09
05/15/06	Nursing Spectrum/Career Fair	Peggy Szarzynski	Administrative Assistant	2.09
05/31/06	American Red Cross/Cpr Training	Cheryl Griffin	Staff Education/Training Manager	3.34
05/31/06	Ill Health Care Assoc/Licensure Exam Review	Jessica O'Neall	Social Service Manager	28.79
06/22/06	American Red Cross/Skill Assessment	Cheryl Griffin	Staff Education/Training Manager	1.67
06/22/06	Baudville/Materials	Joan Rubino	Director Human Resources	3.15
06/23/06	Oriental Trading/Materials	Joan Rubino	Director Human Resources	3.65
06/30/06	American Red Cross/Cpr Instructor Course	Cheryl Griffin	Staff Education/Training Manager	17.52
06/01/05	Culture Training	Lisa Custardo	Executive Director	113.16
		Joel Rusco	President/CEO	113.16
		Joan Rubino	Director of Human Resources	113.16
		Wendy Berk	Administrator	113.16
		Terry Arya	VP of Development	113.16
		Kudus Badmus	Director of Finance	113.16
		Lois Kramer	Administrator	113.16
		Randy Cooper	Administrator	113.16
		Cindy Hilsabeck	Administrator	113.16
		Jeannine Zupo	Director of PR/Marketing	113.16
				<u>113.16</u>
				\$ 2,135.74

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	DI 251	1