

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0047266

Facility Name: Marklund Richard Home

Address: 1 South 410 Wyatt Drive Geneva 60134
 Number City Zip Code

County: Kane

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

HFS ID Number: 362652532

Date of Initial License for Current Owners: 06/09/06

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
IRS Exemption Code _____	<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: Kudus Badmus **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 07/01/06 to 06/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

Facility Name & ID Number Marklund Richard Home

0047266 Report Period Beginning: 07/01/06 Ending: 06/30/07

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>4,683</u>	<u>128</u>	<u>0</u>	<u>4,811</u>	13
14	TOTALS	<u>4,683</u>	<u>128</u>		<u>4,811</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.38%

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

194 (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 06/16/06

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

YES Date _____ NO

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

YES NO If YES, enter 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: 06/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number

Marklund Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	27,252	2,009	2,458	31,719		31,719	31,719			1
2	Food Purchase		43,066		43,066		43,066	43,066			2
3	Housekeeping	14,300	6,114	24	20,438		20,438	20,438			3
4	Laundry	11,380	2,510		13,890		13,890	13,890			4
5	Heat and Other Utilities			33,282	33,282		33,282	33,282			5
6	Maintenance	17,532	3,673	18,901	40,106		40,106	40,106			6
7	Other (specify):* Disposal Services			2,940	2,940		2,940	2,940			7
8	TOTAL General Services	70,464	57,372	57,605	185,441		185,441	185,441			8
	B. Health Care and Programs										
9	Medical Director			4,086	4,086		4,086	4,086			9
10	Nursing and Medical Records	457,026	27,405	166,711	651,142		651,142	651,142			10
10a	Therapy		1,023	70	1,093		1,093	1,093			10a
11	Activities	10,400	6,779		17,179		17,179	17,179			11
12	Social Services	2,080			2,080		2,080	2,080			12
13	CNA Training		1,232		1,232		1,232	1,232			13
14	Program Transportation	10,400		7,241	17,641		17,641	17,641			14
15	Other (specify):* Vision, Dental, Pharmacy, Psychologist Consultants			1,098	1,098		1,098	1,098			15
16	TOTAL Health Care and Programs	479,906	36,439	179,206	695,551		695,551	695,551			16
	C. General Administration										
17	Administrative	40,303			40,303		40,303	40,303			17
18	Directors Fees										18
19	Professional Services			8,203	8,203		8,203	(4,318)	3,885		19
20	Dues, Fees, Subscriptions & Promotions			12,945	12,945		12,945	(2,953)	9,992		20
21	Clerical & General Office Expenses	45,712	21,216	6,572	73,500	(2,210)	71,290	71,290			21
22	Employee Benefits & Payroll Taxes			125,669	125,669		125,669	125,669			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,666	1,666		1,666	1,666			24
25	Other Admin. Staff Transportation			2,547	2,547		2,547	2,547			25
26	Insurance-Prop.Liab.Malpractice			22,403	22,403		22,403	22,403			26
27	Other (specify):* Fund-Raising/Promotional			1,693	1,693		1,693	(1,693)			27
28	TOTAL General Administration	86,015	21,216	181,698	288,929	(2,210)	286,719	(8,964)	277,755		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	636,385	115,027	418,509	1,169,921	(2,210)	1,167,711	(8,964)	1,158,747		29

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

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			120,068	120,068		120,068	(7,561)	112,507		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,841	4,841		4,841	(4,841)			32
33	Real Estate Taxes			1	1		1	(1)			33
34	Rent-Facility & Grounds			6,991	6,991		6,991	(6,991)			34
35	Rent-Equipment & Vehicles					2,210	2,210		2,210		35
36	Other (specify):*										36
37	TOTAL Ownership			131,901	131,901	2,210	134,111	(19,394)	114,717		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			23,698	23,698		23,698		23,698		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			23,698	23,698		23,698		23,698		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	636,385	115,027	574,108	1,325,520		1,325,520	(28,358)	1,297,162		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 Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,841)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,953)	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	(4,318)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,665)	27		24
25	Fund Raising, Advertising and Promotional	(28)	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	(14,552)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,357)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (28,357)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Marklund Richard Home

ID# 0047266

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	depreciation	\$ (7,561)	30	1
2	real estate taxes	(1)	33	2
3	rent	(6,991)	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	Total	(14,553)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,318)	0	0	0	0	0	0	0	0	0	0	(4,318)	19
20	Fees, Subscriptions & Promotions	(2,953)	0	0	0	0	0	0	0	0	0	0	(2,953)	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):*	(1,693)	0	0	0	0	0	0	0	0	0	0	(1,693)	27
28	TOTAL General Administration	(8,964)	0	0	0	0	0	0	0	0	0	0	(8,964)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,964)	0	0	0	0	0	0	0	0	0	0	(8,964)	29

STATE OF ILLINOIS

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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	(7,561)	0	0	0	0	0	0	0	0	0	0	(7,561)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,841)	0	0	0	0	0	0	0	0	0	0	(4,841)	32
33	Real Estate Taxes	(1)	0	0	0	0	0	0	0	0	0	0	(1)	33
34	Rent-Facility & Grounds	(6,991)	0	0	0	0	0	0	0	0	0	0	(6,991)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,394)	0	(19,394)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(28,358)	0	(28,358)	45									

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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 Richard Home # 0047266 Report Period Beginning: 07/01/06 Ending: 06/30/07

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 Richard Home

0047266 Report Period Beginning: 07/01/06

Ending: 06/30/07

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	13,080,887	13,080,887	\$ 142	\$ 1,129,478	\$ 12	1	
2	2	Food	Direct Cost Budget	13,080,887	13,080,887	56	1,129,478	5	2	
3	3	Housekeeping	Direct Cost Budget	13,080,887	13,080,887	6,835	1,129,478	590	3	
4	5	Utilities	Direct Cost Budget	13,080,887	13,080,887	82,116	1,129,478	7,090	4	
5	6	Maintenance	Direct Cost Budget	13,080,887	13,080,887	35,812	1,129,478	3,092	5	
6	7	Disposal	Direct Cost Budget	13,080,887	13,080,887	12,312	1,129,478	1,063	6	
7	13	BNATP	Direct Cost Budget	13,080,887	13,080,887	1,340	1,129,478	116	7	
8	14	Transportation	Direct Cost Budget	13,080,887	13,080,887	6,025	1,129,478	520	8	
9	19	Professional Services	Direct Cost Budget	13,080,887	13,080,887	45,000	1,129,478	3,886	9	
10	20	Fees, Subscription	Direct Cost Budget	13,080,887	13,080,887	110,857	1,129,478	9,572	10	
11	21	Clerical/Office	Direct Cost Budget	13,080,887	13,080,887	211,509	587,793	1,129,478	18,263	11
12	22	Benefits	Direct Cost Budget	13,080,887	13,080,887	116,074	1,129,478	10,022	12	
13	24	Travel & Seminars	Direct Cost Budget	13,080,887	13,080,887	9,744	1,129,478	841	13	
14	25	Staff Transportation	Direct Cost Budget	13,080,887	13,080,887	16,119	1,129,478	1,392	14	
15	26	Insurance	Direct Cost Budget	13,080,887	13,080,887	25,414	1,129,478	2,194	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 679,355	\$ 587,793	\$ 58,658	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			
A. Directly Facility Related																				
Long-Term																				
1	N/A									1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	N/A									6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	N/A									10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	15										

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2002	_____	8		
2003	_____	9		
2004	_____	10		
2005	_____	11		
2006	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Richard Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047266

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

TELEPHONE (630) 593-5487 FAX #: (630) 593-5481

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>
TOTALS		<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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Richard Home

0047266 Report Period Beginning:

07/01/06 Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,815 B. General Construction Type: Exterior Brick/Cedar Frame Wood/Steel Number of Stories 1

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

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

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

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

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

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

Marklund Hyde Center Day Training 43,000 Square Feet 102 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

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

Marklund Mill Creek Home 3 16-Bed Facility 8,815 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>2004</u>	<u>\$ 329,981</u>	1
2					2
3	TOTALS			\$ 329,981	3

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	16		2006	2006	\$ 1,404,275	\$ 70,214	20	\$ 70,214		\$ 105,321	4
5			2006	2006	106,795	10,679	10	10,679		16,019	5
6			2006	2006	42,499	4,250	10	4,250		6,375	6
7											7
8											8
Improvement Type**											
9		Single-faced sandblasted cedar signage		2007	1,450	145	5	145		145	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

*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 Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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)	\$ 1,555,019	\$ 85,288		\$ 85,288	\$	\$ 127,860	70

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

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

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	\$ 125,899	\$ 22,629	\$ 22,629	\$		\$ 42,266	71
72	Current Year Purchases	16,929	2,050	2,050			2,050	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 142,827	\$ 24,679	\$ 24,679	\$		\$ 44,316	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	2006 Ford El Dorado (1/6)	2006	\$ 8,080	\$ 808	\$ 808	\$	5	\$ 808	76
77	Maintenance	2003 Ford F-250 (1/6)	2004	2,834	567	567		5	1,984	77
78	Courier	2007 Ford Focus (1/6)	2006	2,238	224	224		5	224	78
79	Snow Plow	F-350 Snow Plow (1/6)	2003	4,706	941	941		5	4,236	79
80	TOTALS			\$ 17,858	\$ 2,540	\$ 2,540	\$		\$ 7,251	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,045,685	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,507	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,507	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)	\$ 179,427	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	TOTAL				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 2,210 Description: Office Equipment/Machinery

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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	TOTAL			\$		\$	\$		\$	14

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

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

Ending:

06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 549,253	\$ 549,253	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>139,500</u>)	3,405,505	3,405,505	3
4	Supply Inventory (priced at)	37,470	37,470	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	63,914	63,914	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Client related accounts</u>	612,169	612,169	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,668,311	\$ 4,668,311	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,417,615	6,417,615	13
14	Buildings, at Historical Cost	22,601,650	22,601,650	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,630,994	4,630,994	16
17	Accumulated Depreciation (book methods)	(11,839,921)	(11,839,921)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,238,545	5,238,545	21
22	Other Long-Term Assets (specify):	4,428,261	4,428,261	22
23	Other(specify): <u>Construction in progress</u>	117,694	117,694	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,594,838	\$ 31,594,838	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 36,263,149	\$ 36,263,149	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 356,716	\$ 356,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	312,906	312,906	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,648	21,648	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
	Other Current Liabilities(specify):			
36	<u>Other: Compensation & Related Payables</u>	883,264	883,264	36
37	<u>Misc. Other</u>	2,899,523	2,899,523	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,974,057	\$ 4,974,057	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,974,057	\$ 4,974,057	46
47	TOTAL EQUITY (page 18, line 24)	\$ 31,289,092	\$ 31,289,092	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 36,263,149	\$ 36,263,149	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,167,884	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,167,884	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(168,567)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	783,293	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Remaining Cosolidated Income (loss)	258,019	15
16	Other (describe) Change in Unrealized Gains (losses)	(666,685)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 206,060	17
B. Transfers (Itemize):			
18	Transfer out of Restricted Funds into Operations - Exp	(84,852)	18
19	Transfer out of Restricted Funds into Operations - Capital	(190,466)	19
20	Transfer into Operations from Restricted Funds	190,466	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (84,852)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,289,092	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Richard Home# 0047266Report Period Beginning: 07/01/06Ending: 06/30/07**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,093,810	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,093,810	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	34,785	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,785	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,128,595	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	185,441	31
32	Health Care	695,551	32
33	General Administration	277,755	33
B. Capital Expense			
34	Ownership	114,717	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	23,698	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,297,162	40
41	Income before Income Taxes (line 30 minus line 40)**	(168,567)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (168,567)	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 Richard Home

0047266

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	59	62	\$ 1,612	\$ 31.00	1
2	Assistant Director of Nursing	1,976	2,080	45,067	26.00	2
3	Registered Nurses	5,197	5,470	114,845	25.19	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	23,258	24,482	265,217	13.00	5
6	CNA Trainees					6
7	Licensed Therapist	850	894	17,836	23.93	7
8	Rehab/Therapy Aides	395	416	4,680	13.50	8
9	Activity Director					9
10	Activity Assistants	988	1,040	10,400	12.00	10
11	Social Service Workers	198	208	2,080	12.00	11
12	Dietician					12
13	Food Service Supervisor	494	520	9,655	22.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,976	2,080	14,473	8.35	15
16	Dishwashers	494	520	3,124	7.21	16
17	Maintenance Workers	1,087	1,144	17,532	18.39	17
18	Housekeepers	1,976	2,080	14,300	8.25	18
19	Laundry	1,640	1,726	11,380	7.91	19
20	Administrator	1,186	1,248	40,303	38.75	20
21	Assistant Administrator					21
22	Other Administrative	2,371	2,496	41,713	20.05	22
23	Office Manager					23
24	Clerical	316	333	3,999	14.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	27,733	16.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	257	270	2,553	11.33	31
32	Other Health Care(specify)	988	1,040	10,400	12.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	47,682	50,189	\$ 658,902 *	\$ 13.13	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	34	\$ 1,687	1	35
36	Medical Director	monthly	4,086	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	56	2,815	10	38
39	Pharmacist Consultant	monthly	245	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	70	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	7	629	15	46
47	<u>Vision</u>	9	199	15	47
48	<u>Dental</u>	1	25	15	48
49	TOTAL (lines 35 - 48)	109	\$ 9,756		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,350	\$ 103,171	10	50
51	Licensed Practical Nurses	42	1,301	10	51
52	Certified Nurse Assistants/Aides	3,619	59,425	10	52
53	TOTAL (lines 50 - 52)	6,011	\$ 163,897		53

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning: 07/01/06

Ending: 06/30/07

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			\$ 40,303	Workers' Compensation Insurance	\$ 14,626	IDPH License Fee	\$		
				Unemployment Compensation Insurance	4,385	Advertising: Employee Recruitment	8,924		
				FICA Taxes	50,406	Health Care Worker Background Check			
				Employee Health Insurance	38,333	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	420		
				Pension	13,618	Misc. Dues/Subscriptions	648		
				Dental	3,785				
				Life Insurance/Disability	516				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 40,303	TOTAL (agree to Schedule V, line 22, col.8)			\$ 125,669		
(List each licensed administrator separately.)				TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,992		
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	1,666	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,666
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
KPMG	audit fees	\$ 3,885							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,885						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

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 -\$420
- (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? 5year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,230 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. \$ 23,698
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 \$5,000, 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
07/18/06	Home CEU Connection	Jalpa Pandya	THERAPY MGR	15.88
08/31/06	Pediatric Resources	Dena Schultz	Speech/Language Therapist	35.71
09/30/06	Illinois Healthcare/56th Convention	Len Pablo	Administrator MCH	95.36
11/13/06	CPR Savers/First Aid	Cheryl Griffin	STAFF/TRAINING MGR	49.45
11/14/06	McKESSON-CPR Materials	Cheryl Griffin	STAFF/TRAINING MGR	51.53
11/15/06	McKESSON-CPR Materials	Cheryl Griffin	STAFF/TRAINING MGR	9.25
11/30/06	Southwest Seminars-Nursing Law	Randy Dragoo	RN	18.22
		Rena Thibault	DIRECTOR OF NURSING	18.22
		Erica Kelley	RN	18.22
12/04/06	Lippincott-Resource Nursing Books	Rena Thibault	DIRECTOR OF NURSING	35.59
01/15/07	College DuPage-Nursing Course	Rena Thibault	DIRECTOR OF NURSING	74.83
		Randy Dragoo	RN	74.84
02/13/07	WorldPoint ECC CPR/1st Aid Materials	Alice Morgan	CPR	52.67
03/01/07	Lippincott-Resource Nursing Books	Rena Thibault	DIRECTOR OF NURSING	7.15
04/30/07	University of Wisconsin Cont'd Ed	Rose Vicker	PHYSICAL THERAPY	12.50
05/31/07	INR Cont'd Ed	Lois Kramer	ADMINISTRATOR	8.78
		Jalpa Pandya	THERAPY MGR	8.78
05/31/07	Cross Country Ed/Neuro & Sensory	Jalpa Pandya	THERAPY MGR	18.78
		Joanna Vicker	OCCUPATIONAL THERAPIST	18.77
01/11/07	Rockhurst Univ-Excel in Supervising	Lisa Custardo	EXECUTIVE DIRECTOR	40.00
		Wendy Berk	ADMINISTRATOR	40.00
		Joan Rubino	DIR HUMAN RESOURCES	40.00
		Lisa Espisito	DEVELOPMENT INSTRUCTOR	40.00
		Kudus Badmus	DIRECTOR OF FINANCE	40.00
07/13/06	Plat Plus-Skill Path-Ass't Seminar	Sarah Jensen	Administrator Assistant	12.69
08/14/06	Plat Plus-Carf	Joan Rubino	Director Human Resources	131.25
08/18/06	Carf	Joan Rubino	Director Human Resources	6.30
11/06/06	Market Net-Culture Cases	Joan Rubino	Director Human Resources	38.79
02/13/07	Plat Plus-Padgett Seminar-Books	Joan Rubino	Director Human Resources	15.97
02/27/07	Chief of Police-Symposium on Reports	Joan Rubino	Director Human Resources	0.43
03/31/07	Plat Plus-Learnlive Tech	Lisa Custardo	Executive Director	4.31
05/31/07	Fred Pryor-Seminar Tape-Payroll	MaryLou McDuffee	Payroll Risk Mgmt	15.46
06/13/07	Bank of America-Get Motivated Seminar	Joan Rubino	Director Human Resources	6.69
06/01/07	Culture Training	Lisa Custardo	Executive Director	76.19
		Joel Rusco	President/CEO	76.19
		Joan Rubino	Director of Human Resources	76.19
		Wendy Berk	Administrator	76.19
		Kudus Badmus	Director of Finance	76.19
		Lois Kramer	Administrator	76.19
		Cindy Hilsabeck	Administrator	76.19
		Jeannine Zupo	Director of PR/Marketing	76.19
				\$1,665.94

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	Di 2010	1