

Facility Name & ID Number Marklund Van Der Molen Home

0045559 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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,334	365	0	5,699
14	TOTALS	5,334	365		5,699

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.59%

D. How many bed-hold days during this year were paid by the Department? 30 (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 08/04/06

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

ACCRUAL 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.

STATE OF ILLINOIS

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Facility Name & ID Number Marklund Van Der Molen Home # 0045559 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				Reclassification 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	32,703	1,853	3,393	37,949		37,949		37,949		1
2	Food Purchase		44,149		44,149		44,149		44,149		2
3	Housekeeping	17,160	6,453	24	23,637		23,637		23,637		3
4	Laundry	13,656	2,626		16,282		16,282		16,282		4
5	Heat and Other Utilities			35,304	35,304		35,304		35,304		5
6	Maintenance	20,273	3,647	13,160	37,080		37,080		37,080		6
7	Other (specify):* Disposal Services			2,625	2,625		2,625		2,625		7
8	TOTAL General Services	83,792	58,728	54,506	197,026		197,026		197,026		8
B. Health Care and Programs											
9	Medical Director			5,129	5,129		5,129		5,129		9
10	Nursing and Medical Records	552,604	35,557	156,812	744,973		744,973		744,973		10
10a	Therapy	27,019	624	70	27,713		27,713		27,713		10a
11	Activities	12,854	5,784		18,638		18,638		18,638		11
12	Social Services	2,496			2,496		2,496		2,496		12
13	CNA Training		1,232		1,232		1,232		1,232		13
14	Program Transportation	12,480		7,241	19,721		19,721		19,721		14
15	Other (specify):* Vision, Dental, Pharmacy, Psychologist Consultants			1,014	1,014		1,014		1,014		15
16	TOTAL Health Care and Programs	607,453	43,197	170,266	820,916		820,916		820,916		16
C. General Administration											
17	Administrative	48,363			48,363		48,363		48,363		17
18	Directors Fees										18
19	Professional Services			8,203	8,203		8,203	(4,318)	3,885		19
20	Dues, Fees, Subscriptions & Promotions			13,364	13,364		13,364	(2,953)	10,411		20
21	Clerical & General Office Expenses	59,025	19,335	6,526	84,886	(2,259)	82,627		82,627		21
22	Employee Benefits & Payroll Taxes			157,709	157,709		157,709		157,709		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,641	1,641		1,641		1,641		24
25	Other Admin. Staff Transportation			6,573	6,573		6,573		6,573		25
26	Insurance-Prop.Liab.Malpractice			22,403	22,403		22,403		22,403		26
27	Other (specify):* Fund-Raising Promotional			1,695	1,695		1,695	(1,695)			27
28	TOTAL General Administration	107,388	19,335	218,114	344,837	(2,259)	342,578	(8,966)	333,612		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	798,633	121,260	442,886	1,362,779	(2,259)	1,360,520	(8,966)	1,351,554		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 Van Der Molen Home

#0045559

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			96,324	96,324		96,324	(11,579)	84,745			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					2,259	2,259		2,259			35
36	Other (specify):*											36
37	TOTAL Ownership			108,157	108,157	2,259	110,416	(23,412)	87,004			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			74,507	74,507		74,507		74,507			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			74,507	74,507		74,507		74,507			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	798,633	121,260	625,550	1,545,443		1,545,443	(32,378)	1,513,065			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 Van Der Molen Home

0045559

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	(1,667)	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	(18,571)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (32,378)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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))	\$ (32,378)		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

Marklund Van Der Molen Home

ID# 0045559

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	depreciation	\$ (11,579)	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	(18,571)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Van Der Molen Home

0045559

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):*	(1,695)	0	0	0	0	0	0	0	0	0	0	(1,695)	27
28	TOTAL General Administration	(8,966)	0	0	0	0	0	0	0	0	0	0	(8,966)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,966)	0	0	0	0	0	0	0	0	0	0	(8,966)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Van Der Molen Home # 0045559 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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(11,579)	0	0	0	0	0	0	0	0	0	0	(11,579) 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	(23,412)	0	0	0	0	0	0	0	0	0	0	(23,412) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(32,378)	0	0	0	0	0	0	0	0	0	0	(32,378) 45

Facility Name & ID Number Marklund Van Der Molen Home

0045559

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 Van Der Molen Home # 0045559 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 Van Der Molen Home # 0045559 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	13,080,887	13,080,887	\$ 142	\$	1,129,478	\$ 12	1
2	2	Food	13,080,887	13,080,887	56		1,129,478	5	2
3	3	Housekeeping	13,080,887	13,080,887	6,835		1,129,478	590	3
4	5	Utilities	13,080,887	13,080,887	82,116		1,129,478	7,090	4
5	6	Maintenance	13,080,887	13,080,887	35,812		1,129,478	3,092	5
6	7	Disposal	13,080,887	13,080,887	12,312		1,129,478	1,063	6
7	13	BNATP	13,080,887	13,080,887	1,340		1,129,478	116	7
8	14	Transportation	13,080,887	13,080,887	6,025		1,129,478	520	8
9	19	Professional Services	13,080,887	13,080,887	45,000		1,129,478	3,886	9
10	20	Fees, Subscription	13,080,887	13,080,887	110,857		1,129,478	9,572	10
11	21	Clerical/Office	13,080,887	13,080,887	211,509	587,793	1,129,478	18,263	11
12	22	Benefits	13,080,887	13,080,887	116,074		1,129,478	10,022	12
13	24	Travel & Seminars	13,080,887	13,080,887	9,744		1,129,478	841	13
14	25	Staff Transportation	13,080,887	13,080,887	16,119		1,129,478	1,392	14
15	26	Insurance	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

Facility Name & ID Number Marklund Van Der Molen Home # 0045559 Report Period Beginning: 07/01/06 Ending: 06/30/07

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

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

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

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

Facility Name & ID Number **Marklund Van Der Molen Home**

0045559 Report Period Beginning: **07/01/06** Ending: **06/30/07**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2006 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:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		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
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,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Van Der Molen Home COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045559

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

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

A. Summary of Real Estate Tax Costs

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. 11-24-100-029	Residential - Tax Exempt	\$ None	\$ None
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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 Van Der Molen Home

0045559 Report Period Beginning:

07/01/06 Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,315 B. General Construction Type: Exterior Brick/Cedar Frame Wood/Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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 CapacityMarklund Haverkamp Home 16-Bed Facility 8,315 Square Feet 16 Person CapacityMarklund Tommy Home 16-Bed Facility 8,315 Square Feet 16 Person CapacityMarklund Sayers Home 16-Bed Facility 8,315 Square Feet 16 Person CapacityMarklund Mill Creek Home 3 16-Bed Facility 8,815 Square Feet 16 Person CapacityMarklund Richard Home 16-Bed Facility 8,815 Square Feet 16 Person CapacityF. 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	Long Term Care	37,200	1999	\$ 175,688	1
2					2
3	TOTALS	37,200		\$ 175,688	3

Facility Name & ID Number Marklund Van Der Molen Home

0045559

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	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2003	2003	\$ 1,225,273	\$ 61,264	20	\$ 61,264	\$	\$ 214,423	4
5		2003	2003	42,170	4,217	10	4,217		14,759	5
6										6
7										7
8										8
Improvement Type**										
9	Electrical Upgrade	2003	2003	3,222	644	5	644		2,255	9
10	Gutter Installation	2004	2004	383	77	5	77		268	10
11	Emergency Battery Lights-generator	2005	2005	333	33	10	33		83	11
12	Sealcoating of driveway and paths	2005	2005	1,712	428	2	428		1,712	12
13	Grading and Seeding of land parcel	2005	2005	301	60	5	60		150	13
14	Bollard lighting	2005	2005	1,300	260	5	260		650	14
15	Concrete slabs by dumpster	2006	2006	1,950	390	5	390		585	15
16	Custom exterior signage	2006	2006	1,227	245	5	245		368	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

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)		\$ 1,277,869	\$ 67,618		\$ 67,618	\$	\$ 235,254	70

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

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	\$ 88,549	\$ 14,073	\$ 14,073	\$ 0		\$ 47,222	71
72	Current Year Purchases	7,137	513	513			513	72
73	Fully Depreciated Assets	3,395					3,395	73
74								74
75	TOTALS	\$ 99,082	\$ 14,586	\$ 14,586	\$ 0		\$ 51,131	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)	\$ 1,570,498	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 84,745	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 293,636	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.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ 2,259 Description: Office Equipment/Machinery
(Attach a schedule detailing the breakdown of movable equipment)

* 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.

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

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? <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)	\$			

- (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.

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	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Marklund Van Der Molen Home

0045559

Report 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	2	
		Operating	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 139,500)	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): Client related accounts	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): construction in progress	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	2	
		Operating	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	Other: Compensation & Related Payables	883,264	883,264	36
37	Misc. Other	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)	(226,268)	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)	315,720	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 Restrcted Funds into Operations - Exp	(84,852)	18
19	Transfer out of Restrcted Funds into Operations - Capital	(190,466)	19
20	Transfer into Operations from Restrcted 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.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Van Der Molen Home

0045559

Report Period Beginning: 07/01/06

Ending:

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	\$ 1,252,012	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,252,012	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)	\$ 1,286,797	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	197,026	31
32	Health Care	820,916	32
33	General Administration	333,612	33
B. Capital Expense			
34	Ownership	87,004	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	74,507	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,513,065	40
41	Income before Income Taxes (line 30 minus line 40)**	(226,268)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (226,268)	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 Van Der Molen Home

0045559

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	\$ 1,934	\$ 31.00	1
2	Assistant Director of Nursing	1,976	54,080	26.00	2
3	Registered Nurses	5,236	136,910	24.84	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	23,258	318,261	13.00	5
6	CNA Trainees				6
7	Licensed Therapist	850	21,403	23.93	7
8	Rehab/Therapy Aides	395	5,616	13.50	8
9	Activity Director				9
10	Activity Assistants	988	12,854	12.36	10
11	Social Service Workers	198	2,496	12.00	11
12	Dietician				12
13	Food Service Supervisor	494	11,586	22.28	13
14	Head Cook				14
15	Cook Helpers/Assistants	1,976	17,368	8.35	15
16	Dishwashers	494	3,749	7.21	16
17	Maintenance Workers	1,047	20,273	18.39	17
18	Housekeepers	1,976	17,160	8.25	18
19	Laundry	1,640	13,656	7.91	19
20	Administrator	1,186	48,363	38.75	20
21	Assistant Administrator				21
22	Other Administrative	2,569	54,226	20.05	22
23	Office Manager				23
24	Clerical	316	4,799	14.42	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,976	38,355	18.44	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	257	3,064	11.33	31
32	Other Health Care(specify)	988	12,480	12.00	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	47,879	\$ 798,634 *	\$ 15.85	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	42	\$ 2,122	1	35
36	Medical Director	monthly	5,129	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	56	2,815	10	38
39	Pharmacist Consultant	monthly	334	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) Psychologist	4	310	15	46
47	Vision	16	370	15	47
48					48
49	TOTAL (lines 35 - 48)	120	\$ 11,150		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,726	\$ 76,776	10	50
51	Licensed Practical Nurses	104	3,317	10	51
52	Certified Nurse Assistants/Aides	3,453	73,904	10	52
53	TOTAL (lines 50 - 52)	5,283	\$ 153,997		53

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 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. \$ 12,933 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. \$ 74,507
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 benefit: 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	Jessica O'Neall	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	51.54
11/15/06	McKESSON-CPR Materials	Cheryl Griffin	STAFF/TRAINING MGR	9.26
11/30/06	Southwest Seminars-Nursing Law	Randy Dragoo	RN	10.06
		Rena Thibault	DIRECTOR OF NURSING	10.06
		Erica Kelley	RN	10.05
12/04/06	Lippincott-Resource Nursing Books	Rena Thibault	DIRECTOR OF NURSING	35.61
01/15/07	College DuPage-Nursing Course	Rena Thibault	DIRECTOR OF NURSING	74.83
		Randy Dragoo	RN	74.83
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 MCH	8.78
		Jalpa Pandya	THERAPY MGR	8.77
05/31/07	Cross Country Ed/Neuro & Sensory	Jalpa Pandya	THERAPY MGR	18.78
		Joanna Vicker	OCCUPATIONAL THERAPIST	18.78
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
				\$1,641.48

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