

Facility Name & ID Number Marklund Richard Home

0047266 Report Period Beginning: 07/01/07 Ending: 06/30/08

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>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,663</u>	<u>0</u>	<u>0</u>	<u>5,663</u>	13
14	TOTALS	<u>5,663</u>	<u>0</u>	<u>0</u>	<u>5,663</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.70%

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

19 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	33,223	2,077	3,494	38,794		38,794	38,794			1
2	Food Purchase		50,749		50,749		50,749	50,749			2
3	Housekeeping	17,160	5,845	26	23,031		23,031	23,031			3
4	Laundry	13,656	3,576		17,232		17,232	17,232			4
5	Heat and Other Utilities			36,774	36,774		36,774	36,774			5
6	Maintenance	12,240	3,134	15,460	30,834		30,834	30,834			6
7	Other (specify):*			3,554	3,554		3,554	3,554			7
8	TOTAL General Services	76,279	65,381	59,308	200,968		200,968	200,968			8
	B. Health Care and Programs										
9	Medical Director			4,372	4,372		4,372	4,372			9
10	Nursing and Medical Records	605,871	34,766	102,547	743,184		743,184	743,184			10
10a	Therapy	29,010	987	41	30,038		30,038	30,038			10a
11	Activities	30,851	5,133		35,984		35,984	35,984			11
12	Social Services	3,326			3,326		3,326	3,326			12
13	CNA Training		65		65		65	65			13
14	Program Transportation	12,480		18,957	31,437		31,437	31,437			14
15	Other (specify):*			2,452	2,452		2,452	2,452			15
16	TOTAL Health Care and Programs	681,538	40,951	128,369	850,858		850,858	850,858			16
	C. General Administration										
17	Administrative	48,363			48,363		48,363	48,363			17
18	Directors Fees										18
19	Professional Services			6,581	6,581		6,581	(3,805)	2,776		19
20	Dues, Fees, Subscriptions & Promotions			16,533	16,533		16,533	(3,805)	12,728		20
21	Clerical & General Office Expenses	61,886	19,846	8,042	89,774	(2,730)	87,044		87,044		21
22	Employee Benefits & Payroll Taxes			164,775	164,775		164,775		164,775		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,355	1,355		1,355		1,355		24
25	Other Admin. Staff Transportation			1,747	1,747		1,747		1,747		25
26	Insurance-Prop.Liab.Malpractice			22,823	22,823		22,823		22,823		26
27	Other (specify):*			1,668	1,668		1,668	(20,198)	(18,530)		27
28	TOTAL General Administration	110,249	19,846	223,524	353,619	(2,730)	350,889	(27,808)	323,081		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	868,066	126,178	411,201	1,405,445	(2,730)	1,402,715	(27,808)	1,374,907		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: 07/01/07 Ending: 06/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			128,704	128,704		128,704	(11,052)	117,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,877	3,877		3,877	(3,877)				32
33	Real Estate Taxes			1	1		1	(1)				33
34	Rent-Facility & Grounds			9,145	9,145		9,145	(9,145)				34
35	Rent-Equipment & Vehicles					2,730	2,730		2,730			35
36	Other (specify):*											36
37	TOTAL Ownership			141,727	141,727	2,730	144,457	(24,075)	120,382			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			65,529	65,529		65,529		65,529			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,529	65,529		65,529		65,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	868,066	126,178	618,457	1,612,701		1,612,701	(51,883)	1,560,818			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: 07/01/07

Ending: 06/30/08

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	(3,877)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,805)	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	(3,805)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,198)	27		24
25	Fund Raising, Advertising and Promotional				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	(20,198)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,883)		\$	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))	\$ (51,883)		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						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: 07/01/07

Ending: 06/30/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Depreciation	\$ (11,052)	30
2	Real Estate Taxes	(1)	33
3	Rent	(9,145)	34
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	(20,198)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	(3,805)	0	0	0	0	0	0	0	0	0	0	(3,805)	19
20	Fees, Subscriptions & Promotions	(3,805)	0	0	0	0	0	0	0	0	0	0	(3,805)	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):*	(20,198)	0	0	0	0	0	0	0	0	0	0	(20,198)	27
28	TOTAL General Administration	(27,808)	0	0	0	0	0	0	0	0	0	0	(27,808)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,808)	0	0	0	0	0	0	0	0	0	0	(27,808)	29

STATE OF ILLINOIS

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/07 Ending:

Summary B

06/30/08

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	(11,052)	0	0	0	0	0	0	0	0	0	0	(11,052)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,877)	0	0	0	0	0	0	0	0	0	0	(3,877)	32
33	Real Estate Taxes	(1)	0	0	0	0	0	0	0	0	0	0	(1)	33
34	Rent-Facility & Grounds	(9,145)	0	0	0	0	0	0	0	0	0	0	(9,145)	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	(24,075)	0	(24,075)	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)	(51,883)	0	(51,883)	45									

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning:

07/01/07

Ending:

06/30/08

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:

07/01/07

Ending:

06/30/08

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: 07/01/07

Ending: 06/30/08

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	13,019,730	13,019,730	\$ 196	\$	1,223,904	\$ 18	1
2	2	Food	Direct Cost Budget	13,019,730	13,019,730	492		1,223,904	46	2
3	3	Housekeeping	Direct Cost Budget	13,019,730	13,019,730	5,724		1,223,904	538	3
4	5	Utilities	Direct Cost Budget	13,019,730	13,019,730	81,863		1,223,904	7,695	4
5	6	Maintenance	Direct Cost Budget	13,019,730	13,019,730	36,343		1,223,904	3,416	5
6	7	Disposal	Direct Cost Budget	13,019,730	13,019,730	13,097		1,223,904	1,231	6
7	13	BNATP	Direct Cost Budget	13,019,730	13,019,730	696		1,223,904	65	7
8	14	Transportation	Direct Cost Budget	13,019,730	13,019,730	6,629		1,223,904	623	8
9	19	Professional Services	Direct Cost Budget	13,019,730	13,019,730	35,004		1,223,904	3,291	9
10	20	Fees, Subscription	Direct Cost Budget	13,019,730	13,019,730	126,473		1,223,904	11,889	10
11	21	Clerical/Office	Direct Cost Budget	13,019,730	13,019,730	219,762		1,223,904	20,658	11
12	22	Benefits	Direct Cost Budget	13,019,730	13,019,730	124,140		1,223,904	11,670	12
13	24	Travel & Seminars	Direct Cost Budget	13,019,730	13,019,730	6,095		1,223,904	573	13
14	25	Staff Transportation	Direct Cost Budget	13,019,730	13,019,730	14,005		1,223,904	1,317	14
15	26	Insurance	Direct Cost Budget	13,019,730	13,019,730	27,812		1,223,904	2,614	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 698,332	\$		\$ 65,644	25

Facility Name & ID Number Marklund Richard Home # 0047266 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	<u>N/A</u>						\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	<u>N/A</u>											6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10	<u>N/A</u>											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 2007 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 2008 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:					
2003	_____	8			
2004	_____	9			
2005	_____	10			
2006	_____	11			
2007	_____	12			
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/07 Ending:

06/30/08

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:

07/01/07

Ending:

06/30/08

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		\$ 175,534	4
5			2006	2006	106,795	10,679	10	10,679		26,699	5
6			2006	2006	42,499	4,250	10	4,250		10,625	6
7											7
8											8
		Improvement Type**									
9		Single-faced sandblasted cedar signage		2007	1,450	290	5	290		435	9
10		Lightning Protection System		208	3,100	310	5	310		310	10
11		Hot Rubber Crackfill Repair		2008	427	107	2	107		107	11
12		Sealcoating Driveway/Sidewalks		2008	1,525	381	2	381		381	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:

07/01/07

Ending:

06/30/08

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)	\$ 1,560,071	\$ 86,231		\$ 86,231	\$	\$ 214,091	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: 07/01/07 Ending: 06/30/08

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	\$ 142,827	\$ 26,729	\$ 26,729	\$		\$ 71,045	71
72	Current Year Purchases	6,535	806	806			806	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 149,363	\$ 27,535	\$ 27,535	\$		\$ 71,851	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	Patient Transport	2008 Ford Eldorado (1/2)	2008	\$ 24,925	\$ 2,493	\$ 2,493	\$	5	\$ 2,493	76
77	Snow Plow	2003 Ford F350 (1/6)	2003	5,248	471	471		5	5,248	77
78	Maintenance	2004 F250 (1/6)	2004	2,834	567	567		5	2,551	78
79	Laundry Van/General Use	2008 Ford Cargo Van (1/6)	2008	3,563	356	356		5	356	79
80	TOTALS			\$ 36,570	\$ 3,886	\$ 3,886	\$		\$ 10,648	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)		\$ 2,075,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 117,652	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 117,652	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)		\$ 296,589	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: N/A

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 2,730 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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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 prescrpts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															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: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(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	\$ 936,214	\$ 936,214	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>152,000</u>)	2,855,515	2,855,515	3
4	Supply Inventory (priced at)	46,300	46,300	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	85,173	85,173	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Client related accounts</u>	606,644	606,644	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,529,846	\$ 4,529,846	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,208,149	6,208,149	13
14	Buildings, at Historical Cost	21,145,545	21,145,545	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,548,148	4,548,148	16
17	Accumulated Depreciation (book methods)	(11,826,914)	(11,826,914)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,505,831	5,505,831	21
22	Other Long-Term Assets (specify):	4,239,921	4,239,921	22
23	Other(specify): <u>Construction in progress</u>	649,884	649,884	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,470,564	\$ 30,470,564	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 35,000,410	\$ 35,000,410	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 282,455	\$ 282,455	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	376,608	376,608	30
	Accrued Taxes Payable (excluding real estate taxes)	33,061	33,061	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>Compensation & Related Payables</u>	1,006,524	1,006,524	36
37	<u>Misc. Other</u>	2,994,205	2,994,205	37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,692,853	\$ 4,692,853	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
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,692,853	\$ 4,692,853	46
47	TOTAL EQUITY (page 18, line 24)	\$ 30,307,557	\$ 30,307,557	47
	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,000,410	\$ 35,000,410	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,289,020	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,289,020	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(290,171)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	502,870	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)	(1,123,863)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (911,164)	17
B. Transfers (Itemize):			
18	Transfer out of Restrcted Funds into Operations - Exp	(70,299)	18
19	Transfer out of Restrcted Funds into Operations - Capital	(165,285)	19
20	Transfer into Operations from Restricted Funds	165,285	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (70,299)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 30,307,557	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	\$ 1,238,968	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,238,968	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	63	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)	\$ 63	23
D. Non-Operating Revenue			
24	Contributions	31,616	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,616	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)	\$ 1,270,647	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	200,968	31
32	Health Care	850,858	32
33	General Administration	323,081	33
B. Capital Expense			
34	Ownership	120,382	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	65,529	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,560,818	40
41	Income before Income Taxes (line 30 minus line 40)**	(290,171)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (290,171)	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: 07/01/07

Ending:

06/30/08

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	329	347	\$ 13,499	\$ 38.90	1
2	Assistant Director of Nursing	1,976	2,080	55,432	26.65	2
3	Registered Nurses	5,849	6,157	169,834	27.58	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	23,198	24,419	325,371	13.32	5
6	CNA Trainees					6
7	Licensed Therapist	929	978	23,394	23.92	7
8	Rehab/Therapy Aides	395	416	5,616	13.50	8
9	Activity Director					9
10	Activity Assistants	2,371	2,496	30,851	12.36	10
11	Social Service Workers	257	270	3,326	12.32	11
12	Dietician					12
13	Food Service Supervisor	494	520	11,586	22.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,976	2,080	17,888	8.60	15
16	Dishwashers	494	520	3,749	7.21	16
17	Maintenance Workers	632	666	12,240	18.38	17
18	Housekeepers	1,976	2,080	17,160	8.25	18
19	Laundry	1,640	1,726	13,656	7.91	19
20	Administrator	1,008	1,061	48,363	45.58	20
21	Assistant Administrator					21
22	Other Administrative	2,569	2,704	57,893	21.41	22
23	Office Manager					23
24	Clerical	316	333	3,994	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	38,355	18.44	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care (Transp)	257	270	3,380	12.52	32
33	Other(specify)	988	1,040	12,480	12.00	33
34	TOTAL (lines 1 - 33)	49,630	52,243	\$ 868,067 *	\$ 16.62	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	\$ 2,092	1	35
36	Medical Director	Monthly	4,372	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	177	8,833	10	38
39	Pharmacist Consultant	Monthly		15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	41	10a	42
43	Speech Therapy Consultant			10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	21	1,765	15	46
47	<u>Vision</u>	19	437	15	47
48	<u>Dental</u>	10	250	15	48
49	TOTAL (lines 35 - 48)	270	\$ 17,790		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,116	\$ 49,531	10	50
51	Licensed Practical Nurses	126	4,639	10	51
52	Certified Nurse Assistants/Aides	1,653	39,544	10	52
53	TOTAL (lines 50 - 52)	2,895	\$ 93,714		53

Facility Name & ID Number Marklund Richard Home

0047266

Report Period Beginning: 07/01/07

Ending: 06/30/08

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'Neill	Administrator		\$ 30,449	Workers' Compensation Insurance	\$ 20,581	IDPH License Fee	\$		
Lem Pablo	Asst Administrator		17,914	Unemployment Compensation Insurance	6,380	Advertising: Employee Recruitment	11,223		
				FICA Taxes	66,407	Health Care Worker Background Check			
				Employee Health Insurance	53,221	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		IHCA Dues	839		
				Pension	17,770	Misc. Dues & Subscriptions	666		
				Dental	5,359				
				Life Insurance/Disability	754				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 48,363	TOTAL (agree to Schedule V, line 22, col.8)			\$ 170,472		
B. Administrative - Other							TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount						
N/A									
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Line #	Amount	
C. Professional Services							Description		
Vendor/Payee	Type	Amount					Amount		
KMPG	Audit Fees	3,291		N/A			Out-of-State Travel		
							\$		
							In-State Travel		
							Seminar Expense		
							1,355		
							Entertainment Expense		
							(
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,291	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 1,355		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Richard Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association-\$839
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,068 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. \$ 65,529
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? _____
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: KMPG 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	LOCATION	JOB TITLE	COST OF SEMINAR
07/01/07	Rockhurst Univ/Legally Terminate	Joan Rubino	Telephone Seminar	Dir Human Resources	\$ 11.22
07/01/07	Rockhurst Univ/Legally Terminate	Joan Rubino	Telephone Seminar	Dir Human Resources	1.87
07/13/07	Illinois Healthcare/DD Symposium	Jessica O'Neill	Conv Ctr/Springfield	Administrator/MHC	7.99
07/13/07	Illinois Healthcare/DD Symposium	Diana Book	Conv Ctr/Springfield	Administrator Facility Services	7.99
08/13/07	BOA/K-Mart/Note pads, Scissors, Binders	Lisa Custardo	Materials	Executive Director/CFO	14.96
08/13/07	BOA/Barnes & Nobles/Books	Lisa Custardo	Materials	Executive Director/CFO	3.68
08/31/07	Illinois Healthcare/Administrator Review Course	Kudus Badmus	Holiday Inn/Listle	Director of Finance	32.43
09/13/07	BOA/Target/Post its, Clips, Highlighters	Lisa Custardo	Materials	Executive Director/CFO	5.20
09/13/07	BOA/Borders/Books	Lisa Custardo	Materials	Executive Director/CFO	0.30
09/13/07	Waubonsee CC/BLS Instructor Course	Wendy Berk	Waubonsee CC/Sugar Grove	Adm Benefits/Staff Training	18.71
09/13/07	Waubonsee CC/BLS Healthcare Provider Course	Wendy Berk	Waubonsee CC/Sugar Grove	Adm Benefits/Staff Training	6.49
09/13/07	Waubonsee CC/BLS Instructor Course	Emily Myers	Waubonsee CC/Sugar Grove	Devel Instructor/Cert Nurse Asst	18.71
09/21/07	Elburn Fire Dept/CPR and AED Class	Emily Myers	East North St/Elburn	Devel Instructor/Cert Nurse Asst	2.35
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Lois Kramer	Hyatt/Milwaukee WI	Administrator/MCH	34.39
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Wes Kohan	Hyatt/Milwaukee WI	Cert Therapeutic Rec Specialist	34.38
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Carrie Lange	Hyatt/Milwaukee WI	Cert Therapeutic Rec Specialist	34.38
09/30/07	Illinois Healthcare/Convention & Trade Show	Maria Anda	Convention Ctr/Peoria	Therapeutic Activity Aide	29.22
09/30/07	Illinois Healthcare/Convention & Trade Show	Kudus Badmus	Convention Ctr/Peoria	Director of Finance	4.12
09/30/07	Illinois Healthcare/Convention & Trade Show	Diana Book	Convention Ctr/Peoria	Administrator Facility Services	4.12
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Lois Kramer	Hyatt/Milwaukee WI	Administrator/MCH	3.23
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Wes Kohan	Hyatt/Milwaukee WI	Cert Therapeutic Rec Specialist	3.23
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Carrie Lange	Hyatt/Milwaukee WI	Cert Therapeutic Rec Specialist	3.23
09/30/07	Illinois Healthcare/Convention & Trade Show	Vicki Reyes	Convention Ctr/Peoria	Certified Occupational Therapist	4.12
09/30/07	Illinois Healthcare/Convention & Trade Show	Dena Schultz	Convention Ctr/Peoria	Speech Language Pathologist	4.12
09/30/07	Illinois Healthcare/Convention & Trade Show	Joan Rubino	Convention Ctr/Peoria	Dir Human Resources	4.12
09/30/07	Illinois Healthcare/Convention & Trade Show	Deb Dassist	Convention Ctr/Peoria	Occupational Therapist	4.12
09/30/07	American Therapeutic Rec Assoc/ATRA Conf	Carrie Lange	Hyatt/Milwaukee WI	Cert Therapeutic Rec Specialist	3.56
10/13/07	Waubonsee CC/CPR Class	Edyta Dziarkowski	Waubonsee CC/Sugar Grove	Licensed Pratical Nurse	24.88
10/13/07	Ill Dept Regulations/Test	Jessica O'Neill	Prometric Testing Ctr/Sycamore	Administrator/MHC	47.50
10/13/07	Waubonsee CC/CPR Class	Edyta Dziarkowski	Waubonsee CC/Sugar Grove	Licensed Pratical Nurse	2.34
10/16/07	Infinity Rehab/Wheelchair Seating	Vicki Reyes	Holiday Inn/Rolling Meadows	Certified Occupational Therapist	14.14
10/16/07	Infinity Rehab/Wheelchair Seating	Jalpa Pandya	Holiday Inn/Rolling Meadows	Dir Therapy Services	14.14
10/16/07	Infinity Rehab/Wheelchair Seating	Rose Vicker	Holiday Inn/Rolling Meadows	Physical Therapy Assistant	14.15
10/31/07	Education Resources/Sensory Integration	Deb Dassist	New Trier Campus/Northfield	Occupational Therapist	55.00
10/31/07	Education Resources/Sensory Integration	Deb Dassist	New Trier Campus/Northfield	Occupational Therapist	5.17
10/31/07	Education Resources/Continued Education	Gunjan Patel	Pathways Ctr/Glenview	Physical Therapist	23.27
11/13/07	US Green Bldg Council/Green Build Expo	Diana Book	McCormick Place/Chicago	Administrator Facility Services	6.25
11/13/07	US Green Bldg Council/Green Build Expo	Kerry Berg	McCormick Place/Chicago	Lead Maintenance Eng	6.25
11/13/07	BOA/Target/Glue, Pens/Dividers	Lisa Custardo	Materials	Executive Director/CFO	3.32
11/13/07	US Green Bldg Council/Green Build Expo	Diana Book	McCormick Place/Chicago	Administrator Facility Services	0.59
11/13/07	US Green Bldg Council/Green Build Expo	Kerry Berg	McCormick Place/Chicago	Lead Maintenance Eng	0.59
11/28/07	Dept Public Health/Food Service Class	Margaret Burgholzer	Ill Dept Public Health/Downers Grove	Cook	22.86
11/28/07	Dept Public Health/Food Service Class	Margaret Burgholzer	Ill Dept Public Health/Downers Grove	Cook	2.15
11/30/07	Life Services Network/Provider Training	Jessica O'Neill	Doubletree Conf Ctr/Downers Grove	Administrator/MHC	14.17
12/04/07	Alimed/3D Disc on Swallowing/Material	Wendy Berk	Material	Adm Benefits/Staff Training	14.12
12/13/07	New Horizons/Office Productivity	Wendy Berk	Materials	Adm Benefits/Staff Training	82.41
01/18/08	Office Depot/Coaching Class	Lisa Custardo	Materials	Executive Director/CFO	8.03
01/18/08	Office Depot/Coaching Class	Lisa Custardo	Materials	Executive Director/CFO	0.98
01/31/08	Fred Pryor/Career Track/Multiple Priorities	Kathy Garza	Holiday Inn/Elmhurst	Accounting Supervisor	14.01
01/31/08	Fred Pryor/Career Track/Multiple Priorities	Peggy Szarzynski	Holiday Inn/Elmhurst	Finance Assistant	14.01
02/05/08	Diana Book/Food Sanitation Course	Shavon Gardner	Marklund/Geneva	House Parent	50.00
02/05/08	Diana Book/Food Sanitation Course	Mike Dixon	Marklund/Geneva	Housekeeping	4.70
02/05/08	Diana Book/Food Sanitation Course	Peggy Szarzynski	Marklund/Geneva	Finance Assistant	4.70
03/31/08	Skill Path Seminar/First Time Manager/Supr	Kathy Garza	Re-schuled for FY09	Accounting Supervisor	18.71
03/31/08	INR/Burnout, Stress, Fatigue Seminar	Jalpa Pandya	Hilton/Listle	Dir Therapy Services	7.61
03/31/08	GLR of AMTA Conference/Music Therapy	Laurie Schaefer	Westin Hotel/Lombard	Music Therapist	4.00
04/23/08	Waubonsee CC/First Aid Class	DI's & Staff	Waubonsee CC/Sugar Grove	DI's and Staff	9.59
04/30/08	Fred Pryor/Careertrack/Managing Emotions	Jessica O'Neill	Westin Hotel/Oakbrook Terrace	Administrator/MHC	14.84
04/30/08	GE Money Bank/Amazon/Excel 2007	Wendy Berk	Material	Adm Benefits/Staff Training	8.51
04/30/08	Fred Pryor/Careertrack/Managing Emotions	Jessica O'Neill	Westin Hotel/Oakbrook Terrace	Administrator/MHC	16.73
04/30/08	GE Money Bank/Amazon/Excel 2007	Wendy Berk	Material	Adm Benefits/Staff Training	0.80
04/30/08	Fred Pryor/Careertrack/Managing Emotions	Jessica O'Neill	Westin Hotel/Oakbrook Terrace	Administrator/MHC	16.73
04/30/08	GE Money Bank/Amazon/Excel 2007	Wendy Berk	Material	Adm Benefits/Staff Training	0.80
05/31/08	INR/Continued Education/Physical Therapy	Jalpa Pandya	Radisson/Schaumburg	Dir Therapy Services	8.78
05/31/08	Cross Country Ed/Pediatric Patients	Gunjan Patel	Renaissance/Chicago	Physical Therapist	23.63
05/31/08	Cross Country Ed/Pediatric Patients	Jalpa Pandya	Renaissance/Chicago	Dir Therapy Services	23.63
05/31/08	INR/Continued Education/Physical Therapy	Jalpa Pandya	Radisson/Schaumburg	Dir Therapy Services	0.83
06/01/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	54.39
06/01/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	169.93
06/01/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	5.11
06/01/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	15.97
06/01/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	15.97
06/13/08	Nes-Test Feel/CTS Admission Fee	Lisa Custardo	McCormick Place/Chicago	Executive Director/CFO	16.54
06/13/08	Nes-Test Feel/CTS Admission/Test Fee	Lisa Custardo	National-Louis University	Executive Director/CFO	3.76
06/30/08	Hidden Angels Foundation/Multisensory Enviro	Carrie Lange	Renaissance/Chicago	Cert Therapeutic Rec Specialist	49.38
06/30/08	Career Track/Ultimate Supervisor	Geoff Wright	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Emily Myers	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Ruel Nieto	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Jen Gallendez	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Jessica Inman	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Crystal Michels	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Career Track/Ultimate Supervisor	Kany Rojo	MCHC Conf Ctr/Chicago	Devel Instructor/Cert Nurse Asst	12.13
06/30/08	Hidden Angels Foundation/Multisensory Enviro	Carrie Lange	Renaissance/Chicago	Cert Therapeutic Rec Specialist	4.64
31/13/08	WorldPoint ECC/CPR Supplies	Wendy Berk	Material	Adm Benefits/Staff Training	26.87
					\$ 1,355

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	B250	1