

Facility Name & ID Number Marklund Sayers Home

0045575 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 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	5,457	365	0	5,822	13
14	TOTALS	5,457	365		5,822	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.69%

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

18 (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 8/25/03

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

YES Date _____ NO

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	1,675	3,926	38,824		38,824		38,824		1
2	Food Purchase		45,643		45,643		45,643		45,643		2
3	Housekeeping	20,592	5,718	8	26,318		26,318		26,318		3
4	Laundry	11,023	3,513		14,536		14,536		14,536		4
5	Heat and Other Utilities			34,967	34,967		34,967		34,967		5
6	Maintenance	12,240	5,327	15,373	32,940		32,940		32,940		6
7	Other (specify):* Disposal Service			3,635	3,635		3,635		3,635		7
8	TOTAL General Services	77,078	61,876	57,909	196,863		196,863		196,863		8
	B. Health Care and Programs										
9	Medical Director			6,125	6,125		6,125		6,125		9
10	Nursing and Medical Records	629,580	28,322	46,859	704,761		704,761		704,761		10
10a	Therapy	30,503	813	100	31,416		31,416		31,416		10a
11	Activities	30,851	5,555		36,406		36,406		36,406		11
12	Social Services	3,326			3,326		3,326		3,326		12
13	CNA Training		9		9		9		9		13
14	Program Transportation	12,480		19,148	31,628		31,628		31,628		14
15	Other (specify):* Vision,Dental,Pharmacy,Psychologist Consultants			1,578	1,578		1,578		1,578		15
16	TOTAL Health Care and Programs	706,740	34,699	73,810	815,249		815,249		815,249		16
	C. General Administration										
17	Administrative	48,363			48,363		48,363		48,363		17
18	Directors Fees										18
19	Professional Services			5,251	5,251		5,251	(2,378)	2,873		19
20	Dues, Fees, Subscriptions & Promotions			13,455	13,455		13,455	(3,622)	9,833		20
21	Clerical & General Office Expenses	48,526	19,784	9,274	77,584	(2,918)	74,666		74,666		21
22	Employee Benefits & Payroll Taxes			160,558	160,558		160,558		160,558		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,724	2,724		2,724		2,724		24
25	Other Admin. Staff Transportation			1,463	1,463		1,463		1,463		25
26	Insurance-Prop.Liab.Malpractice			21,879	21,879		21,879		21,879		26
27	Other (specify):* fund-raising promo			1,703	1,703		1,703	(1,703)			27
28	TOTAL General Administration	96,889	19,784	216,307	332,980	(2,918)	330,062	(7,703)	322,359		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	880,707	116,359	348,026	1,345,092	(2,918)	1,342,174	(7,703)	1,334,471		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			103,715	103,715		103,715	(9,068)	94,647			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,880	3,880		3,880	(3,880)				32
33	Real Estate Taxes			2	2		2	(2)	0			33
34	Rent-Facility & Grounds			9,180	9,180		9,180	(9,180)	0			34
35	Rent-Equipment & Vehicles					2,918	2,918		2,918			35
36	Other (specify):*											36
37	TOTAL Ownership			116,777	116,777	2,918	119,695	(22,129)	97,566			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			72,837	72,837		72,837		72,837			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			72,837	72,837		72,837		72,837			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	880,707	116,359	537,640	1,534,706		1,534,706	(29,832)	1,504,874			45

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

Marklund Sayers Home

ID# 0045575

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Depreciation	\$ (9,068)	30	1
2	Real Estate Taxes	(2)	33	2
3	Rent	(9,180)	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	(18,249)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Sayers Home# 0045575

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(2,378)	0	0	0	0	0	0	0	0	0	0	(2,378)	19
20	Fees, Subscriptions & Promotions	(3,622)	0	0	0	0	0	0	0	0	0	0	(3,622)	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):*	(1,703)	0	0	0	0	0	0	0	0	0	0	(1,703)	27
28	TOTAL General Administration	(7,703)	0	(7,703)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,703)	0	(7,703)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Sayers Home# 0045575

Report Period Beginning:

07/01/08 Ending:06/30/09

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	(9,068)	0	0	0	0	0	0	0	0	0	0	(9,068)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,880)	0	0	0	0	0	0	0	0	0	0	(3,880)	32
33	Real Estate Taxes	(2)	0	0	0	0	0	0	0	0	0	0	(2)	33
34	Rent-Facility & Grounds	(9,180)	0	0	0	0	0	0	0	0	0	0	(9,180)	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	(22,129)	0	0	0	0	0	0	0	0	0	0	(22,129)	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)	(29,832)	0	0	0	0	0	0	0	0	0	0	(29,832)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Marklund Sayers Home # 0045575 Report Period Beginning: 07/01/08 Ending: 06/30/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Marklund Sayers Home

0045575

Report Period Beginning:

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Ending: 06/30/09

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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	13,061,882	13061882	\$ 86	\$ 1,242,514	\$ 8	1
2	2	Food	Direct Cost Budget	13,061,882	13061882	1,130	1,242,514	107	2
3	3	Housekeeping	Direct Cost Budget	13,061,882	13061882	5,792	1,242,514	551	3
4	5	Utilities	Direct Cost Budget	13,061,882	13061882	71,551	1,242,514	6,806	4
5	6	Maintenance	Direct Cost Budget	13,061,882	13061882	31,030	1,242,514	2,952	5
6	7	Disposal	Direct Cost Budget	13,061,882	13061882	11,171	1,242,514	1,063	6
7	13	BNATP	Direct Cost Budget	13,061,882	13061882	98	1,242,514	9	7
8	14	Transportation	Direct Cost Budget	13,061,882	13061882	7,122	1,242,514	677	8
9	19	Professional Services	Direct Cost Budget	13,061,882	13061882	30,200	1,242,514	2,873	9
10	20	Fees,Subscription	Direct Cost Budget	13,061,882	13061882	94,547	1,242,514	8,994	10
11	21	Clerical/Office	Direct Cost Budget	13,061,882	13061882	208,536	1,242,514	19,837	11
12	22	Benefits	Direct Cost Budget	13,061,882	13061882	98,196	1,242,514	9,341	12
13	24	Travel & Seminar	Direct Cost Budget	13,061,882	13061882	15,808	1,242,514	1,504	13
14	25	Staff Transportation	Direct Cost Budget	13,061,882	13061882	9,860	1,242,514	938	14
15	26	Insurance	Direct Cost Budget	13,061,882	13061882	21,007	1,242,514	1,998	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 606,134	\$	\$ 57,658	25

Facility Name & ID Number

Marklund Sayers Home

0045575

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 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 2009 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:	2004	<u>N/A</u>			8
	2005				9
	2006				10
	2007				11
	2008				12
	FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

<u>Marklund Hyde Center</u>	<u>Day Training</u>	<u>43,000 Square Feet</u>	<u>102 Person Capacity</u>
<u>Marklund Haverkamp Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Vandermolen Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Tommy Home</u>	<u>16-Bed Facility</u>	<u>8,315 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Mill Creek Home 3</u>	<u>16-Bed Facility</u>	<u>8,815 Square Feet</u>	<u>16 Person Capacity</u>
<u>Marklund Richard Home</u>	<u>16-Bed Facility</u>	<u>8,815 Square Feet</u>	<u>16 Person Capacity</u>

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Long Term Care</u>	<u>67,518</u>	<u>1999</u>	<u>\$ 318,871</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	67,518		\$ 318,871	3

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	\$	\$ 336,950	4
5		2003	2003	76,537	7,654	10	7,654		42,096	5
6										6
7										7
8										8
Improvement Type**										
9	Electrical Upgrade		2003	3,199	345	5	345		3,199	9
10	Gutter Installation		2004	383	38	5	38		383	10
11	Emergency battery lights - generator		2005	333	33	10	33		150	11
12	Sealcoating of driveway and paths		2005	1,712		2			1,712	12
13	Grading and seeding of land parcel		2005	301	60	5	60		271	13
14	Bollard Lighting		2005	1,300	260	5	260		1,170	14
15	Concrete slabs by dumpsters		2006	1,950	390	5	390		1,365	15
16	Custom exterior signage		2006	1,227	245	5	245		859	16
17	Painting of Syres Homes-Interior		2007	4,683	1,041	5	1,041		2,082	17
18	Lightning Protection System		2008	3,100	620	5	620		930	18
19	Tile Installation Under Kitchen Cabinets		2008	771	154	5	154		231	19
20	Hot Rubber Crackfill Repair		2008	427	214	2	214		320	20
21	Sealcoating Driveway/Sidewalk		2008	1,525	763	2	763		1,144	21
22	Installation of 2 Bollard Lights		2009	637	64	5	64		64	22
23	Epoxy Bathroom Floors		2009	5,858	586	5	586		586	23
24	Oak Plywood Shelving		2009	1,045	105	5	105		105	24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Sayers Home

0045575

Report Period Beginning:

07/01/08

Ending:

06/30/09

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)		\$ 1,330,262	\$ 73,834		\$ 73,834	\$	\$ 393,615	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	\$ 95,166	\$ 13,818	\$ 13,818	\$		\$ 66,958	71
72	Current Year Purchases	10,130	1,013	1,013			1,013	72
73	Fully Depreciated Assets	6,497					6,497	73
74								74
75	TOTALS	\$ 111,793	\$ 14,831	\$ 14,831	\$		\$ 74,468	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	\$ 4,985	\$ 4,985	\$	5	\$ 7,478	76
77	Snow Plow	2003 Ford F350 (1/6)	2003	5,248				5	5,248	77
78	Maintenance	2004 Ford F250 (1/6)	2004	2,834	283	283		5	2,834	78
79	Laundry Van/General Use	2008 Ford Cargo Van (1/6)	2008	3,563	713	713		5	1,069	79
80	TOTALS			\$ 36,570	\$ 5,981	\$ 5,981	\$		\$ 16,629	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)	\$ 1,797,495	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,647	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,647	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)	\$ 484,711	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

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: \$ 2,918 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

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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 checked="" 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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	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 Sayers Home# 0045575Report Period Beginning: 07/01/08Ending: 06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09

(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	\$ 394,282	\$ 394,282	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>164,000</u>)	3,744,419	3,744,419	3
4	Supply Inventory (priced at)	58,250	58,250	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	82,328	82,328	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	533,198	533,198	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,812,477	\$ 4,812,477	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,224,013	6,224,013	13
14	Buildings, at Historical Cost	21,280,368	21,280,368	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,688,789	4,688,789	16
17	Accumulated Depreciation (book methods)	(13,444,146)	(13,444,146)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,703,931	5,703,931	21
22	Other Long-Term Assets (specify):	2,998,355	2,998,355	22
23	Other(specify): <u>construction in progress</u>	2,090,560	2,090,560	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,541,870	\$ 29,541,870	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,354,347	\$ 34,354,347	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 536,232	\$ 536,232	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,046,980	1,046,980	29
30	Accrued Salaries Payable	381,341	381,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,244	34,244	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>	997,170	997,170	36
37	<u>Misc. Other</u>	3,090,637	3,090,637	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,086,604	\$ 6,086,604	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)	\$ 6,086,604	\$ 6,086,604	46
47	TOTAL EQUITY (page 18, line 24)	\$ 28,267,743	\$ 28,267,743	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,354,347	\$ 34,354,347	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,307,557	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,307,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,504,874)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	720,962	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)	(1,173,170)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,957,082)	17
	B. Transfers (Itemize):		
18	Transfer out of Restrcted Funds into Operations - Exp	(82,732)	18
19	Transfer out of Restrcted Funds into Operations - Capital	(440,130)	19
20	Transfer into Operations from Restricted Funds	440,130	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (82,732)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 28,267,743	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Sayers Home# 0045575Report Period Beginning: 07/01/08Ending: 06/30/09

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
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	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		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	196,863	31
32	Health Care	815,249	32
33	General Administration	322,359	33
B. Capital Expense			
34	Ownership	97,566	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	72,837	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,504,874	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,504,874)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,504,874)	43

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

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

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

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

Facility Name & ID Number **Marklund Sayers Home**

0045575

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	6,027	6,344	179,631	28.32	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	22,862	24,066	327,545	13.61	5
6	CNA Trainees					6
7	Licensed Therapist	988	1,040	24,887	23.93	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	2,371	2,496	20,592	8.25	18
19	Laundry	1,324	1,394	11,023	7.91	19
20	Administrator	1,008	1,061	48,363	45.58	20
21	Assistant Administrator					21
22	Other Administrative	1,976	2,080	44,533	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	32,802	15.77	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	257	270	3,380	12.52	31
32	Other Health Care(specify)	988	1,040	12,480	12.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	49,017	51,599	\$ 863,417 *	\$ 16.73	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	\$ 2,100	1	35
36	Medical Director	Monthly	6,125	9	36
37	Medical Records Consultant				37
38	Nurse Consultant	35	1,733	10	38
39	Pharmacist Consultant	Monthly	152	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	3	100	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	15	1,286	15	46
47	<u>Vision</u>	6	140	15	47
48	<u>Dental</u>				48
49	TOTAL (lines 35 - 48)	101	\$ 11,636		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	256	\$ 14,763	10	50
51	Licensed Practical Nurses	171	7,950	10	51
52	Certified Nurse Assistants/Aides	764	22,413	10	52
53	TOTAL (lines 50 - 52)	1,191	\$ 45,126		53

Facility Name & ID Number Marklund Sayers Home# 0045575Report Period Beginning: 07/01/08Ending: 06/30/09**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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,420 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. \$ 72,837
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: KPMG
- (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.