		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

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

I. IDPH Facility ID Number: 0033704

Facility Name: Deicke Ctr-Marklund Chl Home

Address: 27W751 Shady Way (Number) Winfield (City) 60190 (Zip Code)

County: DuPage

Telephone Number: (630)529-2018 **Fax #** (630)529-9128

IDPA ID Number: 36-2652532

Date of Initial License for Current Owners: 3/18/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501-(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira **Telephone Number:** (630)529-2018 Ext. 2232

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/00 to 6/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Joel Rusco
(Title) President & CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	42	TOTALS	42	15,330	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	14,699	365		15,064	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,699	365		15,064	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.26%

D. How many bed-hold days during this year were paid by Public Aid?
144 (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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/18/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/00-6/30/01 Fiscal Year: 7/1/00-6/30/01

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	160,867	6,778	7,492	175,137		175,137		175,137			1
2	Food Purchase		103,763		103,763		103,763		103,763			2
3	Housekeeping	83,616	15,635		99,251		99,251		99,251			3
4	Laundry	25,254	10,153		35,407		35,407		35,407			4
5	Heat and Other Utilities			63,227	63,227		63,227		63,227			5
6	Maintenance	45,717	12,545	28,396	86,658		86,658		86,658			6
7	Other (specify):*			12,323	12,323		12,323		12,323			7
8	**TOTAL General Services**	315,454	148,874	111,438	575,766		575,766		575,766			8
	B. Health Care and Programs											
9	Medical Director			19,597	19,597		19,597		19,597			9
10	Nursing and Medical Records	1,021,840	107,895	120,357	1,250,092		1,250,092		1,250,092			10
10a	Therapy	255,822	6,436	28,810	291,068		291,068		291,068			10a
11	Activities	34,500	12,212	3,200	49,912		49,912		49,912			11
12	Social Services	44,373			44,373		44,373		44,373			12
13	Nurse Aide Training											13
14	Program Transportation			26,502	26,502		26,502		26,502			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,356,535	126,543	198,466	1,681,544		1,681,544		1,681,544			16
	C. General Administration											
17	Administrative	70,500			70,500		70,500		70,500			17
18	Directors Fees											18
19	Professional Services			13,361	13,361		13,361	(1,939)	11,422			19
20	Dues, Fees, Subscriptions & Promotions			37,277	37,277		37,277		37,277			20
21	Clerical & General Office Expenses	141,568	61,222	28,178	230,968		230,968		230,968			21
22	Employee Benefits & Payroll Taxes			429,485	429,485		429,485		429,485			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,465	3,465		3,465		3,465			24
25	Other Admin. Staff Transportation			8,375	8,375		8,375		8,375			25
26	Insurance-Prop.Liab.Malpractice			28,413	28,413		28,413		28,413			26
27	Other (specify):* Fund-raising/Promo			1,044,124	1,044,124		1,044,124	(1,044,124)				27
28	**TOTAL General Administration**	212,068	61,222	1,592,678	1,865,968		1,865,968	(1,046,063)	819,905			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,884,057	336,639	1,902,582	4,123,278		4,123,278	(1,046,063)	3,077,215			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 Deicke Ctr-Marklund Chl Home #0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			181,672	181,672		181,672	(49,992)	131,680			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			1,253	1,253	2,356	3,609	(3,609)				33
34	Rent-Facility & Grounds			22,917	22,917	(2,356)	20,561		20,561			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			205,842	205,842		205,842	(53,601)	152,241			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	27,837	9,270		37,107		37,107		37,107			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,512	144,512		144,512		144,512			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	27,837	9,270	144,512	181,619		181,619		181,619			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,911,894	345,909	2,252,936	4,510,739		4,510,739	(1,099,664)	3,411,075			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 Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(49,992)	30		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	(1,939)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,044,124)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real Estate Taxes	(3,609)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,099,664)		$	30

OHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,099,664)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Deicke Ctr-Marklund Chl Home

ID# **0033704**

Report Period Beginning: **7/1/00**

Ending: **6/30/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Taxes on Rented Site	$ (3,609)	33	1
2				2
3				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**	(3,609)		49

Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	(1,939)
Line 20	0
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	(1,044,124)
Line 28	(1,046,063)
Line 29	(1,046,063)
Line 30	(49,992)
Line 31	0
Line 32	0
Line 33	(3,609)
Line 34	0
Line 35	0
Line 36	0
Line 37	(53,601)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(1,099,664)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	Nurse Aide 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	(1,939)	0	0	0	0	0	0	0	0	0	0	(1,939)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	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):* **fund-raising/Pron**	(1,044,124)	0	0	0	0	0	0	0	0	0	0	(1,044,124)	27
28	**TOTAL General Administration**	(1,046,063)	0	0	0	0	0	0	0	0	0	0	(1,046,063)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,046,063)	0	0	0	0	0	0	0	0	0	0	(1,046,063)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Deicke Ctr-Marklund Chl Home **#** 0033704 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(49,992)	0	0	0	0	0	0	0	0	0	0	(49,992)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(3,609)	0	0	0	0	0	0	0	0	0	0	(3,609)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(53,601)	0	0	0	0	0	0	0	0	0	0	(53,601)	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)**	(1,099,664)	0	0	0	0	0	0	0	0	0	0	(1,099,664)	45

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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 Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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

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

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 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 2001 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 19 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:			
	1996	4,208	8
	1997		9
	1998		10
	1999		11
	2000		12

Note: The taxable property that related to calendar year 1996 (see above) was sold in 11/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Deicke Ctr-Marklund Chl Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0033704

CONTACT PERSON REGARDING THIS REPORT Lisa Lipira

TELEPHONE (630)529-2018 Ext. 2232 FAX #: (630)529-9128

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-13-100-001,002,003	42 bed facility-tax exempt	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 X 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,250 B. General Construction Type: Exterior Brick Frame Single Story Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	110,816	1988	$ 100,000	1
2					2
3	TOTALS	110,816		$ 100,000	3

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	42		1988	1964	$ 669,211	$ 33,461	20	$ 33,461	$	$ 451,718	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replacement of circular drive - Land impr.			1990	1,725		5			1,725	9
10	black top work on driveway - Land Impr.			1992	2,484		5			2,484	10
11	resurfacing of parking lot - Land impr.			1993	810		5			810	11
12	removal/replacement of sidewalk - Land impr.			1994	600		5			600	12
13	stone bed work - Land impr.			1995	2,490	249	5	249		2,490	13
14	tree trimming/landscaping - Land impr			1996	3,055		5			3,055	14
15	pavement,asphalt - Land impr.			1996	15,000	3,000	5	3,000		13,500	15
16	Concrete Work - Land impr.			1999	6,460	1,292	5	1,292		3,230	16
17	Landscaping Land impr.			2000	1,236	247	5	247		371	17
18	Nature Trail - Land impr.			2000	2,100	420	5	420		630	18
19	Replace Parking Lot/Asphalt - Land impr.			2000	5,566	1,113	5	1,113		2,783	19
20	Repair and Resurface Driveway - Land impr.			2000	24,907	181	5	181		2,491	20
21	Security system			1988	2,055		10			2,055	21
22	renovations			1989	230,082	11,504	20	11,504		143,801	22
23	exterior canopy			1990	4,303	215	20	215		2,259	23
24	signage			1990	1,803	90	10	90		1,803	24
25	canopy sprinkler			1990	1,148	57	10	57		1,148	25
26	exterior staining			1991	2,650		5			2,650	26
27	storage shed			1992	899		5			899	27
28	windows			1993	5,838	584	10	584		4,962	28
29	retile tubs			1993	2,000		5			2,000	29
30	ac repair/renovation			1993	547		5			547	30
31	roof repair			1993	2,150		5			2,150	31
32	kitchen floor			1993	5,000		5			5,000	32
33	gutters, downspouts, soffit			1994	5,900	590	10	590		3,835	33
34	master key system			1994	607		5			607	34
35	tiling kitchen walls			1995	1,400		5			1,400	35
36	water heater			1995	3,765	377	5	377		2,447	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 Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Water Closet	1999	$ 732	$ 73	10	$ 73	$	$ 183	37
38	vestibule addition	1999	42,700	4,270	15	4,270		10,675	38
39	exhaust fan	1999	2,000	133	5	133		333	39
40	siding	1999	2,135	427	25	427		1,068	40
41	fire alarm fitting	1999	312	13	10	13		31	41
42	auto doors new enclosure	1999	11,547	1,155	5	1,155		2,887	42
43	flooring new entrance	1999	1,383	277	5	277		692	43
44	painting & renovation	1999	2,650	530	5	530		1,325	44
45	air curtain	1999	767	153	5	153		383	45
46	air curtain	1999	934	187	5	187		467	46
47	flooring/carpeting	1999	42,747	8,549	15	8,549		21,373	47
48	soffits/ceiling/plumbing upgrades	1999	72,156	6,319	10	6,319		13,463	48
49	Electric sliding door	2000	1,322	132	5	132		132	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)		$ 1,187,176	$ 75,598		$ 75,598	$	$ 716,462	70

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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	$ 156,691	$ 32,373	$ 32,373	$	5	$ 107,814	71
72	Current Year Purchases	24,960	2,990	2,990		5	2,990	72
73	Fully Depreciated Assets	89,126					89,126	73
74								74
75	TOTALS	$ 270,777	$ 35,363	$ 35,363	$		$ 199,930	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	Maintenance	2000 Isuzu Truck	2000	$ 31,007	$ 6,201	$ 6,201	$	5	$ 9,302	76
77	General Use	1996 Ford 4X4	1996	20,537	4,107	4,107		5	18,482	77
78	Patient Transport	1999 Bluebird Bus	1998	73,186	10,411	10,411		5	36,767	78
79										79
80	TOTALS			$ 124,730	$ 20,719	$ 20,719	$		$ 64,551	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)	$ 1,682,683	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,680	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,680	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)	$ 980,943	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	Leasehold Improvements (1990-2001)	$ 52,928	$ 12,365	$ 61,327	86
87	Equipment (1990-2001)	264,118	37,627	198,814	87
88					88
89					89
90					90
91	TOTALS	$ 317,046	$ 49,992	$ 260,141	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Berkson & Sons, Ltd.

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 [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	0	4/96	$ 20,561	5	5	3
4	Additions							4
5								5
6								6
7	TOTAL				$ 20,561 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/00
Ending 5/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2002	$ 18,566
13.	6/30/2003	$ 19,123
14.	6/30/2004	$ 19,697

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

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

16. Rental Amount for movable equipment: $ 3,812 Description: Office Equipment
(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	N/A		$	$	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.

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	Nurse Aide 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 aides from other facilities.

$

D. NUMBER OF AIDES 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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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	Exceptional Care Program	Line 39, Col. 8	1265 hrs.	27,837			9,270		37,107	12
13	Other (specify):									13
14	TOTAL			$ 27,837		$	$ 9,270		$ 37,107	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/01 (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	$ 2,060,657	$ 2,060,657	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 61,500)	2,200,630	2,200,630	3
4	Supply Inventory (priced at Cost)	47,355	47,355	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	94,498	94,498	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Funds	456,714	456,714	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,859,854	$ 4,859,854	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	4,082,158	4,082,158	13
14	Buildings, at Historical Cost	5,550,716	5,550,716	14
15	Leasehold Improvements, at Historical Cost	319,570	319,570	15
16	Equipment, at Historical Cost	3,454,231	3,454,231	16
17	Accumulated Depreciation (book methods)	(5,898,568)	(5,898,568)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,397,506	10,397,506	21
22	Other Long-Term Assets (spe Board Restr.	879,338	879,338	22
23	Other(specify): Construction In Progress	694,818	694,818	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 19,479,769	$ 19,479,769	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,339,623	$ 24,339,623	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 480,629	$ 480,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,578	191,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,076	15,076	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	Misc. Other Accrued	2,010,110	2,010,110	36
37	Client Related Liability	456,714	456,714	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,154,107	$ 3,154,107	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)**	$ 3,154,107	$ 3,154,107	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,185,516	$ 21,185,516	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,339,623	$ 24,339,623	48

***(See instructions.)**

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,516,486	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,516,486	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,847,362)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,752,251	11
12	Expenditures for Specific Purposes	(74,077)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Income**	1,177,779	15
16	Other (describe) **Change in Unrealized Gains/(Loss)**	(339,561)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,669,030	17
	B. Transfers (Itemize):		
18	**Trf out of Restriced Funds into Operations-expenses**	(92,880)	18
19	**Trf out of Restriced Funds into Operations-PP&E**	(2,891,297)	19
20	**Trf into Operations from Restricted Funds-expenses**	92,880	20
21	**Trf into Operations from Restricted Funds-PP&E**	2,891,297	21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 21,185,516	24 *

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

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,656,471	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,656,471	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	Nurses Aide 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	6,906	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,906	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)**	$ 2,663,377	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	575,766	31
32	Health Care	1,681,544	32
33	General Administration	1,865,968	33
	B. Capital Expense		
34	Ownership	205,842	34
	C. Ancillary Expense		
35	Special Cost Centers	37,107	35
36	Provider Participation Fee	144,512	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,510,739	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,847,362)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,847,362)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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 Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,976	2,080	$ 53,331	$ 25.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,846	14,575	302,762	20.77	3
4	Licensed Practical Nurses	1,252	1,318	22,069	16.74	4
5	Nurse Aides & Orderlies	51,274	53,973	643,677	11.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,453	2,582	52,742	20.43	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,427	2,554	34,500	13.51	10
11	Social Service Workers	2,964	3,120	44,373	14.22	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	34,320	16.50	13
14	Head Cook	2,766	2,912	35,876	12.32	14
15	Cook Helpers/Assistants	5,470	5,758	66,610	11.57	15
16	Dishwashers	1,976	2,080	24,062	11.57	16
17	Maintenance Workers	2,336	2,459	45,717	18.59	17
18	Housekeepers	9,814	10,330	83,616	8.09	18
19	Laundry	2,964	3,120	25,254	8.09	19
20	Administrator	2,284	2,404	70,500	29.33	20
21	Assistant Administrator					21
22	Other Administrative	6,895	7,258	141,568	19.51	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,017	9,492	135,147	14.24	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,754	6,057	67,933	11.22	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN Exceptl Care	1,202	1,265	27,837	22.01	33
34	TOTAL (lines 1 - 33)	128,646	135,417	$ 1,911,894 *	$ 14.12	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	154	$ 7,106	1	35
36	Medical Director	Monthly	19,597	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	549	28,810	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	78	6,670	10	46
47					47
48					48
49	TOTAL (lines 35 - 48)	781	$ 62,183		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,086	113,687	10	52
53	TOTAL (lines 50 - 52)	5,086	$ 113,687		53

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Bowen-Weyrich	Adm. Support		$ 8,100
Lois Kramer	Administrator		62,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,500

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 4,650
Huck Bouma & Martin, Fenech & Pachulski, P.C.	Legal Fees	8,711
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 13,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,242
Unemployment Compensation Insurance	7,867
FICA Taxes	146,260
Employee Health Insurance	141,597
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	79,013
Dental Plan	11,395
Life Insurance	1,111
TOTAL (agree to Schedule V, line 22, col.8)	$ 429,485

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,920
Health Care Worker Background Check (Indicate # of checks performed)	
IHCA Dues	1,970
Misc. Licenses and Permits	211
Misc. Dues and Subscriptions	4,176
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,277

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,465
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,465

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Deicke Ctr-Marklund Chl Home # 0033704 **Report Period Beginning:** 7/1/00 **Ending:** 6/30/01

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 Health Care Assoc. $1,970**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,751** 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 of Public Aid during this cost report period. $ **144,512**
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? **No** 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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(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. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Marklund Deicke Home
IDPH Fadility ID Number #0033074
Fiscal Year 2001
Schedule V. Cost Center Expenses

Line # 33 & Line #34

Reclassification:

Real Estate Taxes reclassed from Rent-Facility to Real Estate Taxes - based on Schedule XII. Rental Costs instructions related to Section A., question #2	$2,356.00

Marklund Deicke Home
IDPH Fadility ID Number #0033074
Fiscal Year 2001
Schedule VI. Adjustment Detail

Line #29:

Adjustment: Non-Allowable

Real Estate Taxes	$3,609.00

Marklund Deicke Home
IDPH Fadility ID Number #0033074
Fiscal Year 2001
Schedule XIX. Section C.
Summary of Legal Services

Check #	Amount	Personnel	General Business
77064	$33.00		$33.00
77564	$520.00	$520.00	
78275	$1,478.00	$1,222.25	$255.75
78298	$1,318.00		$1,318.00
78868	$1,408.52	$80.00	$1,328.52
79163	$353.91		$353.91
80424	$1,660.54		$1,660.54
Totals	**$6,771.97**	**$1,822.25**	**$4,949.72**

Marklund Deicke Home
IDPH Fadility ID Number #0033074
Fiscal Year 2001
Schedule XIX.
Seminars

NAME	JOB TITLE	DATE	OCATION OF SEMINA	SPONOR/TITLE	AMOUNT
MELISSA CAPENIGOR	CTS/QMRP	8/17/2000	AURORA	THERAPUTIC RECREATIONAL	60
LAURIE SCHAFER	QMRP	8/17/2000	AURORA	THERAPUTIC RECREATIONAL	60
PAT PETERMAN	SOCIAL SERVICE MANAGER	9/14/2000	CHICAGO	UIC/ DHD	75
CAROL SAXON	NURSE	10/7/2000	GLEN ELLYN	COD	49
LOIS KRAMER	ADMINISTRATOR	12/2&9/00	ST.CHARLES	IHCA	275
SUE MOLENKAMP	RESIDENT AVOCATE	12/1/2000	LISLE	RAY GRAHAM	65
LAURIE SCHAFER	QMRP	12/1/2000	LISLE	RAY GRAHAM	65
LOIS KRAMER	ADMINISTRATOR	01/01/01	BLOOMINGDALE	COD-TEAM BUILDING	111
JEANETTE ANDERSON	ADMINISTRATIVE ASSISTANT	01/01/01	BLOOMINGDALE	COD-TEAM BUILDING	111
DIANA BOOK	DIRECTOR SUPPORT SERVICE	01/01/01	BLOOMINGDALE	COD-TEAM BUILDING	111
JALPA PANDYA	PHYSICAL THERAPIST	2/22-26/01	GLENVIEW	PATHWAY	134.71
MELISSA CAPENIGOR	CTS/QMRP	4/23-25/01	ST. LOUIS, MO	MIDWEST SYMPOSIUM	180
LOIS KRAMER	ADMINISTRATOR	3/8/2001	ST. CHARLES	WESSEL & PAUTSCH P.C.	80
JALPA PANDYA	PHYSICAL THERAPIST	3/15-19/01	GLENVIEW	PATHWAY	203.82
JESSICA ULRICH	QMRP	4/23-25/01	ST. LOUIS, MO	MIDWEST SYMPOSIUM	110
VALERIE MAGETT	DON, MDH	4/1/2001	WINFIELD	PULMONARY EXCHANG	30
JALPA PANDYA	PHYSICAL THERAPIST	4/6-9/01	GLENVIEW	PATHWAY	203.82
TARA MCKENNIE	ASSISTANT ADMINISTRATOR	6/26/2001	SPRINGFIELD	IHCA	30.68
DIANA BOOK	DIRECTOR SUPPORT SERVICE	7/22-26/01	NEW ORLEANS	DMA	210
JALPA PANDYA	PHYSICAL THERAPIST	5/18-22/01	GLENVIEW	PATHWAY	203.82
DIANA BOOK	DIRECTOR SUPPORT SERVICE	5/19-22/01	CHICAGO	NATIONAL RESTURANT	40
RAFAEL CALLEGO	COOK	5/19-22/01	CHICAGO	NATIONAL RESTURANT	40
VALERIE MAGETT	DON, MDH	6/5&6/01	SPRINGFIELD	SIU SCHOOL OF MEDICINE	65
DIANA BOOK	DIRECTOR SUPPORT SERVICE	06/01/01	WINFIELD	SANITATION MATERIALS	31.87
TERRI BOWEN, LOIS KRAMER	ADMINISTRATOR, SUPPORT	07/01/01	WINFIELD	FOX VALLEY FIRE & SAFTEY	585
JALPA PANDYA	PHYSICAL THERAPIST	6/8-12/01	GLENVIEW	PATHWAY	203.82
VALERIE MAGETT	DON, MDH	6/27/2001	WINFIELD	CPR SEMINAR-VAL	130
					$3,464.54

Marklund Deicke Home
IDPH Fadility ID Number #0033074
Fiscal Year 2001
Schedule XII.
Listing of Movable Equipment

Description	Quantity
Zerox Fax 3006	1
Minolta 4000 Copier	2