		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 South Prairie Avenue (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: 630 (529-2871) **Fax #** (630) 529-3266

HFS ID Number:

Date of Initial License for Current Owners: 10/01/68

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501 (c) 3

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 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) Lisa Custardo

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Lynn Melvin Telephone Number: (630)593-5485
Email Address:

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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		Skilled (SNF)			1
2	30	Skilled Pediatric (SNF/PED)	30	10,950	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,950	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	7,107	365	0	7,472	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,107	365		7,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.24%

D. How many bed-hold days during this year were paid by the Department?
154 (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 [X]

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 10/01/68

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

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 N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		750	4,330	5,080		5,080		5,080			1
2	Food Purchase		53,930		53,930		53,930		53,930			2
3	Housekeeping	48,256	7,904	37	56,197		56,197		56,197			3
4	Laundry	20,268	5,387		25,655		25,655		25,655			4
5	Heat and Other Utilities			56,890	56,890		56,890		56,890			5
6	Maintenance	23,995	8,202	39,040	71,237		71,237		71,237			6
7	Other (specify):*			11,323	11,323		11,323		11,323			7
8	**TOTAL General Services**	92,519	76,173	111,620	280,312		280,312		280,312			8
	B. Health Care and Programs											
9	Medical Director			25,138	25,138		25,138		25,138			9
10	Nursing and Medical Records	997,565	130,541	65,411	1,193,517	(405,344)	788,173		788,173			10
10a	Therapy	49,623	3,286	1,891	54,800		54,800		54,800			10a
11	Activities	17,363	15,858		33,221		33,221		33,221			11
12	Social Services	4,992			4,992		4,992		4,992			12
13	CNA Training		116		116		116		116			13
14	Program Transportation			26,747	26,747		26,747		26,747			14
15	Other (specify):*			2,916	2,916		2,916		2,916			15
16	**TOTAL Health Care and Programs**	1,069,543	149,801	122,103	1,341,447	(405,344)	936,103		936,103			16
	C. General Administration											
17	Administrative	77,210			77,210		77,210		77,210			17
18	Directors Fees											18
19	Professional Services			8,508	8,508		8,508	(2,040)	6,468			19
20	Dues, Fees, Subscriptions & Promotions			16,396	16,396		16,396	(7,502)	8,894			20
21	Clerical & General Office Expenses	98,317	44,054	23,226	165,597	(7,656)	157,941		157,941			21
22	Employee Benefits & Payroll Taxes			245,876	245,876		245,876		245,876			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,085	5,085		5,085		5,085			24
25	Other Admin. Staff Transportation			2,716	2,716		2,716		2,716			25
26	Insurance-Prop.Liab.Malpractice			63,149	63,149		63,149		63,149			26
27	Other (specify):*			2,500	2,500		2,500	(2,500)				27
28	**TOTAL General Administration**	175,527	44,054	367,456	587,037	(7,656)	579,381	(12,042)	567,339			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,337,589	270,028	601,179	2,208,796	(413,000)	1,795,796	(12,042)	1,783,754			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Marklund Children's Home #0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			604,080	604,080		604,080	(71,197)	532,883			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,365	16,365		16,365	(16,365)				32
33	Real Estate Taxes			159	159		159	(159)				33
34	Rent-Facility & Grounds			20,807	20,807	7,656	28,463	(20,807)	7,656			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			641,411	641,411	7,656	649,067	(108,528)	540,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					405,344	405,344		405,344			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,972	123,972		123,972		123,972			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			123,972	123,972	405,344	529,316		529,316			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,337,589	270,028	1,366,562	2,974,179		2,974,179	(120,570)	2,853,609			45

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(7,502)	20		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				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	(2,040)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,500)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(92,164)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (120,571)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 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))**	$ (120,571)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Marklund Children's Home

ID# 0011288

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation	$ (71,197)	30	1
2	Real Estate Taxes	(159)	33	2
3	Rent	(20,807)	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**	(92,163)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,040)	0	0	0	0	0	0	0	0	0	0	(2,040)	19
20	Fees, Subscriptions & Promotions	(7,502)	0	0	0	0	0	0	0	0	0	0	(7,502)	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):*	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	27
28	**TOTAL General Administration**	(12,042)	0	0	0	0	0	0	0	0	0	0	(12,042)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,042)	0	0	0	0	0	0	0	0	0	0	(12,042)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(71,197)	0	0	0	0	0	0	0	0	0	0	(71,197)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,365)	0	0	0	0	0	0	0	0	0	0	(16,365)	32
33	Real Estate Taxes	(159)	0	0	0	0	0	0	0	0	0	0	(159)	33
34	Rent-Facility & Grounds	(20,807)	0	0	0	0	0	0	0	0	0	0	(20,807)	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**	(108,528)	0	0	0	0	0	0	0	0	0	0	(108,528)	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)**	(120,570)	0	0	0	0	0	0	0	0	0	0	(120,570)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 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 Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [X]

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	1	Dietary	Direct Cost Budget	13,244,905	13244905	$ 309	$	2,701,844	$ 63	1
2	2	Food	Direct Cost Budget	13,244,905	13244905	996		2,701,844	203	2
3	3	Housekeeping	Direct Cost Budget	13,244,905	13244905	5,708		2,701,844	1,164	3
4	5	Utilities	Direct Cost Budget	13,244,905	13244905	67,453		2,701,844	13,760	4
5	6	Maintenance	Direct Cost Budget	13,244,905	13244905	24,468		2,701,844	4,991	5
6	7	Disposal	Direct Cost Budget	13,244,905	13244905	10,124		2,701,844	2,065	6
7	13	BNATP	Direct Cost Budget	13,244,905	13244905	570		2,701,844	116	7
8	14	Transportation	Direct Cost Budget	13,244,905	13244905	7,122		2,701,844	1,453	8
9	19	Professional Services	Direct Cost Budget	13,244,905	13244905	31,710		2,701,844	6,469	9
10	20	Fees,Subscriptions	Direct Cost Budget	13,244,905	13244905	38,201		2,701,844	7,793	10
11	21	Clerical/Office	Direct Cost Budget	13,244,905	13244905	183,906		2,701,844	37,515	11
12	22	Benefits	Direct Cost Budget	13,244,905	13244905	106,005		2,701,844	21,624	12
13	24	Travel & Seminar	Direct Cost Budget	13,244,905	13244905	19,888		2,701,844	4,057	13
14	25	Staff Transportation	Direct Cost Budget	13,244,905	13244905	5,502		2,701,844	1,122	14
15	26	Insurance	Direct Cost Budget	13,244,905	13244905	25,208		2,701,844	5,142	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 527,170	$		$ 107,537	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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						$	$		$	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 Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

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

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

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Children's Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

TELEPHONE (630) 593-5487 FAX #: (630) 529-3266

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	Residential - Tax exempt	$ None	$
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 _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories

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, CNA 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	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30		1968	1953	$ 68,500	$	33	$	$	$ 68,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LI Parking Lot Concrete Asphalt land impr			1999	300		5			300	9
10	LI Parking Lot Concrete Asphalt land impr			1999	32,199		5			32,199	10
11	LI Parking Lot Concrete Asphalt land impr			2000	300		5			300	11
12	LI Resurface Playground land impr			2000	7,750		5			7,750	12
13	LI Safety Surfacing of Playground			2000	6,094		5			6,094	13
14	LI Landscaping of Playground land impr			2000	3,325		5			3,325	14
15	BI Awnings rear entrance			2000	2,023		5			2,023	15
16	BI lower level classroom renovations			2000	183		5			183	16
17	BI awning for O2 protection			2000	3,477		5			3,477	17
18	BI fire doors lower level			2000	564	28	10	28	(0)	564	18
19	BI carpet flooring lower level			1999	5,855		5			5,855	19
20	BI lower level classroom renovation			1999	1,346		5			1,346	20
21	BI replacement windows			1999	538		5			538	21
22	BI Construction, engineering, architect, inspection			1999	49,390	2,470	10	2,470		49,390	22
23	BI fire sprinkler system			1999	72,843	2,914	25	2,914		30,594	23
24	BI interior design, handrails, corner pieces			1999	29,873	1,992	15	1,992		20,911	24
25	BI Demolition old lower level			1999	26,641	1,322	10	1,322		26,641	25
26	BI Chair rails			1999	8,160		5			8,160	26
27	BI Painting lower level			1999	19,835		5			19,835	27
28	BI lower level construction walls			1999	101,713	5,086	10	5,086		101,713	28
29	BI cabinets			1999	46,002	3,067	15	3,067		32,202	29
30	BI Reg. & auto doors			1999	18,259	913	10	913		18,259	30
31	BI Electrical work lower level			1999	29,697	1,485	10	1,485		29,697	31
32	BI windows/shutters			1999	15,529		10			15,529	32
33	BI Floor/carpeting			1999	46,503		5			46,503	33
34	BI Signage Interior/Exterior			1999	3,899	195	10	195		3,899	34
35	BI Plumbing lower level			1999	21,177	1,059	20	1,059		11,118	35
36	BI ECU Awnings			1999	3,994	266	15	266		2,796	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 Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	BI Paneling	1999	$ 7,309	$	5	$	$	$ 7,309	37
38	BI Security System,Elevator	1999	11,010	734	15	734		7,707	38
39	BI New door hardware	1999	197	10	10	10		197	39
40	BI Fire alarm system upper level	1999	12,491	500	25	500		5,246	40
41	BI Water Heater	2001	767		5			767	41
42	BI Air Curtain	2001	764		5			764	42
43	BI Replacement Parts - Boiler	2001	3,858		5			3,858	43
44	BI Compressor Pump	2001	1,599		5			1,599	44
45	BI Security Door	2001	2,427		5			2,427	45
46	BI Roof Repair	1999	8,800		5			8,800	46
47	BI New compressor	1999	2,580	172	15	172		1,978	47
48	BI Boiler	1998	2,675		5			2,675	48
49	BI Stairwell Door replacements	2001	1,165		5			1,165	49
50	BI New Radiator for generator	2001	3,002		5			3,002	50
51	BI Sliding door repair	2002	4,179		5			4,179	51
52	BI Carpeting	2002	1,690		5			1,690	52
53	BI Awning	2002	2,694		5			2,694	53
54	LI Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571		5			15,571	54
55	BI Renovations: Architect, Engineering, reconstruct	2005	2,571,858	257,186	10	257,186		1,414,522	55
56	BI Renovations: Electrical work	2005	65,707	6,571	10	6,571		36,139	56
57	BI Renovations: Piping and Plumbing	2005	114,194	11,419	10	11,419		62,806	57
58	BI Renovations: Shelving	2005	1,118	112	10	112		615	58
59	BI Hot Water Heater	2005	4,529	453	5	453		4,529	59
60	LI Landscaping: plants, flowers, bushes	2005	4,055	406	5	406		4,055	60
61	LI Outdoor lighting, fencing, landscaping	2005	38,190	3,819	10	3,819		21,005	61
62	LI Exterior signage	2006	5,380	1,076	5	1,076		4,842	62
63	BI Dugout walls w/doors and jams	2006	13,671	2,734	5	2,734		12,304	63
64	BI Roof removal and replacement	2006	62,340	6,234	10	6,234		28,053	64
65	BI Fire door w/metal edge astragals w/door coordinators	2006	1,730	346	5	346		1,557	65
66	BI HVAC Roof repairs	2006	69,022	6,902	10	6,902		31,060	66
67	BI Electrical work for HVAC	2006	3,900	780	5	780		3,510	67
68	BI Asbestos tile and mastic removal exercise room	2006	2,950	590	5	590		2,655	68
69	BI Painting of 4 bedrooms	2006	3,875	775	5	775		3,488	69
70	TOTAL (lines 4 thru 69)		$ 3,671,266	$ 321,616		$ 321,616	$ (0)	$ 2,252,469	70

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	
1	Totals from Page 12A, Carried Forward		$ 3,671,266	$ 321,616		$ 321,616	$ (0)	$ 2,252,469	1
2	LI Tree Removal/ Gravel/ Move Shed - Campsite	2007	1,150	230	5	230		805	2
3	LI MCH Campus Signs	2007	5,380	1,076	5	1,076		3,766	3
4	BI New Carpeting/Base Room 3	2007	4,420	884	5	884		3,094	4
5	BI Asbestos Consulting and Removal	2007	2,614	436	5	436		2,614	5
6	BI Sprinklers for Awnings	2008	2,400	480	5	480		1,200	6
7	BI Awnings	2008	7,826	1,565	5	1,565		3,913	7
8	BI Boiler Repair	2008	2,925	975	3	975		2,438	8
9	BI Electric Receptacles in Wiremold	2008	3,645	729	5	729		1,823	9
10	LI Sidewalk Repair	2008	3,300	660	5	660		1,650	10
11	LI Peace Pole Garden	2009	2,837	567	5	567		851	11
12	BI Insulate Windows / Re-install trim	2009	858	172	5	172		257	12
13	BI Installation of Wiremold Outlets	2009	1,036	207	5	207		311	13
14	BI Carpeting & Installation in Office Area	2009	5,500	1,100	5	1,100		1,650	14
15	BI Labor/ Material - Water Main Repair	2009	2,860	572	5	572		858	15
16	BI Tie doors into Fire System	2009	1,695	377	5	377		377	16
17	LI Driveway Reconstruction	2010	88,608	8,861	5	8,861		8,861	17
18	LI (2) 10'-12' Spruce Trees	2010	4,375	438	5	438		438	18
19	LI Trash enclosure w/ornamental Fencing	2010	6,295	630	5	630		630	19
20	LI Earthwork	2010	33,414	3,341	5	3,341		3,341	20
21	LI Fences and Gates	2010	2,310	231	5	231		231	21
22	LI Sealcoating and striping of Driveway	2010	2,451	613	2	613		613	22
23	LI Trees, shrubs, misc planting	2010	10,240	1,024	5	1,024		1,024	23
24	LI (4) Fat Albert Colorado Blue Spruce Trees	2010	1,660	166	5	166		166	24
25	BI Gutter replacement	2010	1,592	159	5	159		159	25
26	BI Construction/Plumbing Dental lines	2010	143,610	7,181	10	7,181		7,181	26
27	BI Demo/Bldg, Flooring,Masonry,Alarm service	2010	75,010	3,751	10	3,751		3,751	27
28	BI Const/Drywall, Painting, Insulation	2010	98,198	4,910	10	4,910		4,910	28
29	BI Const/Skylights,Door frames,Entrances	2010	111,060	5,553	10	5,553		5,553	29
30	BI Architect,Plans,Surveys,Consults	2010	171,381	8,569	10	8,569		8,569	30
31	BI Structural/Eng Consults,Plans,Reviews	2010	72,963	3,648	10	3,648		3,648	31
32	BI Constructon:Damproofing/Water Protection	2010	7,275	364	10	364		364	32
33	BI Construction Electrical Work	2010	282,582	14,129	10	14,129		14,129	33
34	TOTAL (lines 1 thru 33)		$ 4,832,736	$ 395,214		$ 395,214	$ (0)	$ 2,341,644	34

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	
1	Totals from Page 12B, Carried Forward		$ 4,832,736	$ 395,214		$ 395,214	$ (0)	$ 2,341,644	1
2	BI Construction:Masonry, Concrete,Steel, Roofing	2010	238,586	11,929	10	11,929		11,929	2
3	BI Installation: Blinds and Shades	2010	10,054	503	10	503		503	3
4	BI Construction:Vinyl Flooring, Carpeting	2010	60,995	3,050	10	3,050		3,050	4
5	BI Construction: Geneal Conditions	2010	330,889	16,544	10	16,544		16,544	5
6	BI Installation of Cabinetry	2010	1,990	100	5	100		100	6
7	BI Construction:Heating,Ventilastion,Elevator	2010	335,130	16,757	10	16,757		16,757	7
8	BI Air Testing, Monitoring, Reporting	2010	3,420	171	10	171		171	8
9	BI Construction: Fire Protection System	2010	85,492	4,275	10	4,275		4,275	9
10	BI Construction:Carpentry	2010	341,102	17,055	10	17,055		17,055	10
11	BI Connect back-up Phone, Door	2010	4,800	480	20	480		480	11
12	BI Tuckpointing/Restoration to Chimney Stack	2010	3,475	348	5	348		348	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	TOTAL (lines 1 thru 33)		$ 6,248,669	$ 466,426		$ 466,426	$ (0)	$ 2,412,856	34

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	$ 271,660	$ 39,742	$ 39,742	$		$ 197,610	71
72	Current Year Purchases	152,522	14,334	14,334			14,334	72
73	Fully Depreciated Assets	446,432					446,432	73
74								74
75	TOTALS	$ 870,614	$ 54,076	$ 54,076	$		$ 658,376	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	2004 Isuzu Truck	2004	$ 34,940	$	$	$	4	$ 34,940	76
77	Patient Transport	2006 Ford ElDorado Bus	2006	48,400	9,696	9,696		5	33,936	77
78	Courier	2007 Ford Focus	2007	13,427	2,685	2,685		5	9,399	78
79										79
80	TOTALS			$ 96,767	$ 12,381	$ 12,381	$		$ 78,275	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)	$ 7,247,550	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 532,883	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 532,883	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,149,507	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.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 7,656 Description: Office equipment/Machinery
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs 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 CNA ____

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

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	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.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

		1	2	3	4	5	6	7	8	
	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Exceptional Care Program		12264	313,958			91,386	12,264	405,344	12
13	Other (specify):									13
14	TOTAL			$ 313,958		$	$ 91,386	12,264	$ 405,344	14

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

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/10 (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	$ 96,580	$ 96,580	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,000)	4,981,105	4,981,105	3
4	Supply Inventory (priced at)	67,000	67,000	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	83,857	83,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): client related accounts	556,476	556,476	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,785,018	$ 5,785,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,349,396	6,349,396	13
14	Buildings, at Historical Cost	22,502,264	22,502,264	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,297,114	4,297,114	16
17	Accumulated Depreciation (book methods)	(13,347,015)	(13,347,015)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,696,815	5,696,815	21
22	Other Long-Term Assets (specify):	2,875,845	2,875,845	22
23	Other(specify): construction in progress	12,950	12,950	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,387,369	$ 28,387,369	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 34,172,387	$ 34,172,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,761	$ 226,761	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,384,959	1,384,959	29
30	Accrued Salaries Payable	70,877	70,877	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,365	11,365	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	compesation & related payables	1,080,906	1,080,906	36
37	misc. other	3,008,539	3,008,539	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,783,407	$ 5,783,407	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)**	$ 5,783,407	$ 5,783,407	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 28,388,980	$ 28,388,980	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 34,172,387	$ 34,172,387	48

*(See instructions.)

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 28,267,473	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 28,267,473	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	324,717	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	863,273	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 Consolidated Income**	(958,783)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 229,207	17
	B. Transfers (Itemize):		
18	**Transfers out of Restricted Funds into Operations- exp.**	(107,700)	18
19	**Transfers out of Restricted Funds into Operations-capital**	(762,689)	19
20	**Transfers into Operations from Restricted Funds**	762,689	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (107,700)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 28,388,980	24 *

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	$ 2,296,280	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,296,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	19,020	5
6	Therapy		6
7	Oxygen	36,639	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,659	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	826,387	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 826,387	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)**	$ 3,178,326	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	280,312	31
32	Health Care	936,103	32
33	General Administration	567,339	33
	B. Capital Expense		
34	Ownership	540,539	34
	C. Ancillary Expense		
35	Special Cost Centers	405,344	35
36	Provider Participation Fee	123,972	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,853,609	40
41	**Income before Income Taxes (line 30 minus line 40)****	324,717	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 324,717	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 Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	$ 63,211	$ 30.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,796	17,680	439,428	24.85	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	29,778	31,346	423,166	13.50	5
6	CNA Trainees					6
7	Licensed Therapist	1,363	1,435	44,007	30.67	7
8	Rehab/Therapy Aides	395	416	5,616	13.50	8
9	Activity Director					9
10	Activity Assistants	1,482	1,560	17,363	11.13	10
11	Social Service Workers	395	416	4,992	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,383	1,456	23,995	16.48	17
18	Housekeepers	4,940	5,200	48,256	9.28	18
19	Laundry	2,075	2,184	20,268	9.28	19
20	Administrator	1,976	2,080	77,210	37.12	20
21	Assistant Administrator					21
22	Other Administrative	2,371	2,496	58,431	23.41	22
23	Office Manager					23
24	Clerical	3,359	3,536	39,886	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,952	4,160	66,560	16.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	395	416	5,200	12.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,636	76,461	$ 1,337,589 *	$ 17.49	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	86	$ 4,313	1	35
36	Medical Director	monthly	25,138	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	900	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	54	1,891	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	12	993	15	46
47	Vision	5	123	15	47
48	Dental	36	900	15	48
49	TOTAL (lines 35 - 48)	193	$ 34,258		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	452	$ 40,478	10	50
51	Licensed Practical Nurses	0			51
52	Certified Nurse Assistants/Aides	531	24,933	10	52
53	TOTAL (lines 50 - 52)	983	$ 65,411		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lois Kramer	Administrator		$ 77,210
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,210

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	$ 6,469
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,469

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,086
Unemployment Compensation Insurance	8,365
FICA Taxes	102,325
Employee Health Insurance	76,154
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	21,192
Dental	7,650
Life Insurance	661
Long Term Disability	442
TOTAL (agree to Schedule V, line 22, col.8)	$ 245,875

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	7,019
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks	
Dues/subscriptions	538
IHCA Dues	1,337
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,894

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,085
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,085

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/09 Ending: 06/30/10

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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 Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,133** 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. $ **123,972**
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.

Type	Manufacturer	Model	Qty
Copier	Minolta	BizHub C451	1
Copier	Minolta	BizHub 250	1
Copier	Minolta	BizHub 250	1
Copier	Minolta	BizHub 160	1