FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 S. Prairie Ave. (Number) Bloomingdale (City) 60180 (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
  - [X] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code: 501 (c) 3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 to 06/30/11 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) Gilbert W. Fonger
(Title) President/ CEO

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

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: 07/01/10 Ending: 06/30/11

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	23	Skilled Pediatric (SNF/PED)	23	8,395	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	23	TOTALS	23	8,395	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	7,169	12	0	7,534	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,169	12		7,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.74%

D. How many bed-hold days during this year were paid by the Department?
131 (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: 06/30/11 Fiscal Year: 06/30/11

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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		641	4,714	5,355		5,355		5,355			1
2	Food Purchase		54,068		54,068		54,068		54,068			2
3	Housekeeping	69,120	9,467	36	78,623		78,623		78,623			3
4	Laundry	27,231	5,405		32,636		32,636		32,636			4
5	Heat and Other Utilities			60,431	60,431		60,431		60,431			5
6	Maintenance	23,995	4,807	33,109	61,911		61,911		61,911			6
7	Other (specify):* DISPOSAL			9,595	9,595		9,595		9,595			7
8	**TOTAL General Services**	120,346	74,388	107,885	302,619		302,619		302,619			8
	B. Health Care and Programs											
9	Medical Director			26,280	26,280		26,280		26,280			9
10	Nursing and Medical Records	1,063,197	116,365	39,718	1,219,280	(835,394)	383,886		383,886			10
10a	Therapy	44,492	660	1,701	46,853		46,853		46,853			10a
11	Activities	17,363	5,449		22,812		22,812		22,812			11
12	Social Services	4,992			4,992		4,992		4,992			12
13	CNA Training		81		81		81		81			13
14	Program Transportation			26,194	26,194		26,194		26,194			14
15	Other (specify):* VIS/DEN/RX/PSY			2,111	2,111		2,111		2,111			15
16	**TOTAL Health Care and Programs**	1,130,044	122,555	96,004	1,348,603	(835,394)	513,209		513,209			16
	C. General Administration											
17	Administrative	79,997			79,997		79,997		79,997			17
18	Directors Fees											18
19	Professional Services			8,233	8,233		8,233	(1,974)	6,259			19
20	Dues, Fees, Subscriptions & Promotions			14,305	14,305		14,305	(7,760)	6,545			20
21	Clerical & General Office Expenses	69,367	44,196	21,094	134,657	(9,162)	125,495		125,495			21
22	Employee Benefits & Payroll Taxes			252,341	252,341		252,341		252,341			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,339	4,339		4,339	(4,339)	(0)			24
25	Other Admin. Staff Transportation			6,266	6,266		6,266	(6,266)	0			25
26	Insurance-Prop.Liab.Malpractice			49,427	49,427		49,427		49,427			26
27	Other (specify):* FUND RAISING/PROMO			2,500	2,500		2,500	(2,500)				27
28	**TOTAL General Administration**	149,364	44,196	358,505	552,065	(9,162)	542,903	(22,839)	520,064			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,399,754	241,139	562,394	2,203,287	(844,556)	1,358,731	(22,839)	1,335,892			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: 07/01/10 Ending: 06/30/11

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			552,078	552,078		552,078	(15,747)	536,331			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,539	4,539		4,539	(4,539)				32
33	Real Estate Taxes			164	164		164	(164)	(0)			33
34	Rent-Facility & Grounds			19,937	19,937		19,937	(19,937)	(0)			34
35	Rent-Equipment & Vehicles					9,162	9,162		9,162			35
36	Other (specify):*											36
37	TOTAL Ownership			576,718	576,718	9,162	585,880	(40,387)	545,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					835,394	835,394		835,394			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,158	126,158		126,158		126,158			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			126,158	126,158	835,394	961,552		961,552			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,399,754	241,139	1,265,270	2,906,163		2,906,163	(63,227)	2,842,936			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: 07/01/10 Ending: 06/30/11

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	(4,539)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,760)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,974)	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	(46,454)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,227)		$	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))**	$ (63,227)		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: 07/01/10

Ending: 06/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (4,339)	24	1
2	Travel & Sustenance	(6,266)	25	2
3	Depreciation	(15,747)	30	3
4	Real Estate Taxes	(164)	33	4
5	Rent	(19,937)	34	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**	(46,454)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Marklund Children's Home **#** 0011288 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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	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	(1,974)	0	0	0	0	0	0	0	0	0	0	(1,974)	19
20	Fees, Subscriptions & Promotions	(7,760)	0	0	0	0	0	0	0	0	0	0	(7,760)	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	(4,339)	0	0	0	0	0	0	0	0	0	0	(4,339)	24
25	Other Admin. Staff Transportation	(6,266)	0	0	0	0	0	0	0	0	0	0	(6,266)	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**	(22,839)	0	0	0	0	0	0	0	0	0	0	(22,839)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,839)	0	0	0	0	0	0	0	0	0	0	(22,839)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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	(15,747)	0	0	0	0	0	0	0	0	0	0	(15,747)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,539)	0	0	0	0	0	0	0	0	0	0	(4,539)	32
33	Real Estate Taxes	(164)	0	0	0	0	0	0	0	0	0	0	(164)	33
34	Rent-Facility & Grounds	(19,937)	0	0	0	0	0	0	0	0	0	0	(19,937)	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**	(40,387)	0	0	0	0	0	0	0	0	0	0	(40,387)	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)**	(63,227)	0	0	0	0	0	0	0	0	0	0	(63,227)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	13,062,145	13,062,145	$ 27	$	1,204,871	$ 3	1
2	2	Food	Direct Cost Budget	13,062,145	13,062,145	1,294		1,204,871	119	2
3	3	Housekeeping	Direct Cost Budget	13,062,145	13,062,145	6,825		1,204,871	630	3
4	5	Utilities	Direct Cost Budget	13,062,145	13,062,145	60,561		1,204,871	5,586	4
5	6	Maintenance	Direct Cost Budget	13,062,145	13,062,145	18,276		1,204,871	1,686	5
6	7	Disposal	Direct Cost Budget	13,062,145	13,062,145	10,922		1,204,871	1,007	6
7	13	BNATP	Direct Cost Budget	13,062,145	13,062,145	300		1,204,871	28	7
8	14	Transportation	Direct Cost Budget	13,062,145	13,062,145	6,119		1,204,871	564	8
9	19	Professional Services	Direct Cost Budget	13,062,145	13,062,145	31,710		1,204,871	2,925	9
10	20	Fees,Subscriptions	Direct Cost Budget	13,062,145	13,062,145	26,620		1,204,871	2,455	10
11	21	Clerical/Office	Direct Cost Budget	13,062,145	13,062,145	194,478		1,204,871	17,939	11
12	22	Benefits	Direct Cost Budget	13,062,145	13,062,145	87,257		1,204,871	8,049	12
13	24	Travel & Seminar	Direct Cost Budget	13,062,145	13,062,145	15,926		1,204,871	1,469	13
14	25	Staff Transportation	Direct Cost Budget	13,062,145	13,062,145	6,841		1,204,871	631	14
15	26	Insurance	Direct Cost Budget	13,062,145	13,062,145	23,097		1,204,871	2,130	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 490,253	$		$ 45,221	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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:** 07/01/10 **Ending:** 06/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	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).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2011 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.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		**8**
	2007		**9**
	2008		**10**
	2009		**11**
	2010		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	**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.**

2010 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) 593-5501

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 07/01/10 Ending: 06/30/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

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	Long Term 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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	23		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		10			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		10			49,390	22
23	BI fire sprinkler system			1999	72,843	2,914	25	2,914		33,508	23
24	BI interior design, handrails, corner pieces			1999	29,873	1,992	15	1,992		22,902	24
25	BI Demolition old lower level			1999	26,641		10			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		10			101,713	28
29	BI cabinets			1999	46,002	3,067	15	3,067		35,269	29
30	BI Reg. & auto doors			1999	18,259		10			18,259	30
31	BI Electrical work lower level			1999	29,697		10			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		10			3,899	34
35	BI Plumbing lower level			1999	21,177	1,059	20	1,059		12,177	35
36	BI ECU Awnings			1999	3,994	266	15	266		3,062	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		8,441	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		5,746	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		2,150	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		1,671,708	55
56	BI Renovations: Electrical work	2005	65,707	6,571	10	6,571		42,710	56
57	BI Renovations: Piping and Plumbing	2005	114,194	11,419	10	11,419		74,226	57
58	BI Renovations: Shelving	2005	1,118	112	10	112		727	58
59	BI Hot Water Heater	2005	4,529		5			4,529	59
60	LI Landscaping: plants, flowers, bushes	2005	4,055		5			4,055	60
61	LI Outdoor lighting, fencing, landscaping	2005	38,190	3,819	10	3,819		24,824	61
62	LI Exterior signage	2006	5,380	538	5	538		5,380	62
63	BI Dugout walls w/doors and jams	2006	13,671	1,367	5	1,367		13,671	63
64	BI Roof removal and replacement	2006	62,340	6,234	10	6,234		34,287	64
65	BI Fire door w/metal edge astragals w/door coordinators	2006	1,730	173	5	173		1,730	65
66	BI HVAC Roof repairs	2006	69,022	6,902	10	6,902		37,962	66
67	BI Electrical work for HVAC	2006	3,900	390	5	390		3,900	67
68	BI Asbestos tile and mastic removal exercise room	2006	2,950	295	5	295		2,950	68
69	BI Painting of 4 bedrooms	2006	3,875	388	5	388		3,875	69
70	TOTAL (lines 4 thru 69)		$ 3,671,266	$ 306,108		$ 306,108	$	$ 2,558,565	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 306,108		$ 306,108	$	$ 2,558,565	1
2	LI Tree Removal/ Gravel/ Move Shed - Campsite	2007	1,150	230	5	230		1,035	2
3	LI MCH Campus Signs	2007	5,380	1,076	5	1,076		4,842	3
4	BI New Carpeting/Base Room 3	2007	4,420	884	5	884		3,978	4
5	BI Asbestos Consulting and Removal	2007	2,614	436	3	436		2,614	5
6	BI Sprinklers for Awnings	2008	2,400	480	5	480		1,680	6
7	BI Awnings	2008	7,826	1,565	5	1,565		5,478	7
8	BI Boiler Repair	2008	2,925	488	3	488		2,925	8
9	BI Electric Receptacles in Wiremold	2008	3,645	729	5	729		2,552	9
10	LI Sidewalk Repair	2008	3,300	660	5	660		2,310	10
11	LI Peace Pole Garden	2009	2,837	567	5	567		1,418	11
12	BI Insulate Windows / Re-install trim	2009	858	172	5	172		429	12
13	BI Installation of Wiremold Outlets	2009	1,036	207	5	207		518	13
14	BI Carpeting & Installation in Office Area	2009	5,500	1,100	5	1,100		2,750	14
15	BI Labor/ Material - Water Main Repair	2009	2,860	572	5	572		1,430	15
16	BI Tie doors into Fire System	2009	1,695	377	5	377		753	16
17	LI Driveway Reconstruction	2010	88,608	8,394	10	8,394		17,255	17
18	LI (2) 10'-12' Spruce Trees	2010	4,375	875	5	875		1,321	18
19	LI Trash enclosure w/ornamental Fencing	2010	6,295	1,259	5	1,259		1,889	19
20	LI Earthwork	2010	33,414	3,166	10	3,166		6,507	20
21	LI Fences and Gates	2010	2,310	462	5	462		693	21
22	LI Sealcoating and striping of Driveway	2010	2,451	1,226	2	1,226		1,839	22
23	LI Trees, shrubs, misc planting	2010	10,240	2,048	5	2,048		3,072	23
24	LI (4) Fat Albert Colorado Blue Spruce Trees	2010	1,660	332	5	332		498	24
25	BI Gutter replacement	2010	1,592	318	5	318		478	25
26	BI Construction/Plumbing Dental lines	2010	143,610	6,996	20	6,996		14,177	26
27	BI Demo/Bldg, Flooring,Masonry,Alarm service	2010	75,010	3,654	20	3,654		7,405	27
28	BI Const/Drywall, Painting, Insulation	2010	98,198	4,784	20	4,784		9,694	28
29	BI Const/Skylights,Door frames,Entrances	2010	111,060	5,411	20	5,411		10,964	29
30	BI Architect,Plans,Surveys,Consults	2010	171,381	8,349	20	8,349		16,918	30
31	BI Structural/Eng Consults,Plans,Reviews	2010	72,963	3,555	20	3,555		7,203	31
32	BI Constructon:Damproofing/Water Protection	2010	7,275	728	10	728		1,091	32
33	BI Construction Electrical Work	2010	282,582	13,767	20	13,767		27,896	33
34	TOTAL (lines 1 thru 33)		$ 4,832,736	$ 380,973		$ 380,973	$	$ 2,722,175	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 380,973		$ 380,973	$	$ 2,722,175	1
2	BI Construction:Masonry, Concrete,Steel, Roofing	2010	238,586	11,623	20	11,623		23,553	2
3	BI Installation: Blinds and Shades	2010	10,054	1,005	10	1,005		1,508	3
4	BI Construction:Vinyl Flooring, Carpeting	2010	60,995	6,100	10	6,100		9,149	4
5	BI Construction: Geneal Conditions	2010	330,889	16,120	20	16,120		32,665	5
6	BI Installation of Cabinetry	2010	1,990	199	10	199		299	6
7	BI Construction:Heating,Ventilastion,Elevator	2010	335,130	16,327	20	16,327		33,083	7
8	BI Air Testing, Monitoring, Reporting	2010	3,420	342	10	342		513	8
9	BI Construction: Fire Protection System	2010	85,492	8,549	10	8,549		12,824	9
10	BI Construction:Carpentry	2010	341,102	16,618	20	16,618		33,673	10
11	BI Connect back-up Phone, Door	2010	4,800	960	5	960		1,440	11
12	BI Tuckpointing/Restoration to Chimney Stack	2010	3,475	695	5	695		3,475	12
13	LI 12" Drain, Drain Tile Connect Culvert to Sewer	2011	5,070	507	5	507		507	13
14	LI Gable Style Awning Over Oxygen Storage	2011	1,296	130	5	130		130	14
15	BI Hot Water Heater	2011	1,753	175	5	175		175	15
16	BI Gutter & Downspout Repairs	2011	1,220	122	5	122		122	16
17	BI Replacement of Wall Carpeting	2011	2,980	298	5	298		298	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)		$ 6,260,988	$ 460,744		$ 460,744	$	$ 2,875,588	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 359,740	$ 61,420	$ 61,420	$ 0		$ 209,670	71
72	Current Year Purchases	16,314	1,786	1,786	(0)		1,786	72
73	Fully Depreciated Assets	507,202					507,202	73
74								74
75	TOTALS	$ 883,256	$ 63,206	$ 63,206	$ 0		$ 718,659	75

D. Vehicle Costs. (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	48,480	9,696	9,696		5	43,632	77
78	Courier	2007 Ford Focus	2007	13,427	2,685	2,685		5	12,085	78
79										79
80	TOTALS			$ 96,847	$ 12,381	$ 12,381	$		$ 90,657	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)	$ 7,272,591	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 536,331	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 536,331	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)	$ 3,684,904	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: 07/01/10 Ending: 06/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 9,162 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: 07/01/10 Ending: 06/30/11

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

STATE OF ILLINOIS
0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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		22,679	704,853			130,541	116,365	835,394	12
13	Other (specify):									13
14	TOTAL			$ 704,853		$	$ 130,541	116,365	$ 835,394	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:** 07/01/10 **Ending:** 06/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/11 **(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	$ 731,969	$ 731,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 184,000)	3,195,562	3,195,562	3
4	Supply Inventory (priced at)	71,593	71,593	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	70,344	70,344	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): client related accounts	606,808	606,808	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,676,276	$ 4,676,276	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,420,768	6,420,768	13
14	Buildings, at Historical Cost	22,601,817	22,601,817	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,422,739	4,422,739	16
17	Accumulated Depreciation (book methods)	(15,097,363)	(15,097,363)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,929,876	5,929,876	21
22	Other Long-Term Assets (specify):	4,324,534	4,324,534	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,602,371	$ 28,602,371	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 33,278,647	$ 33,278,647	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,437	$ 224,437	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,279	100,279	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,149	9,149	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	1,209,317	1,209,317	36
37	misc. other	2,829,053	2,829,053	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,372,235	$ 4,372,235	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,372,235	$ 4,372,235	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 27,906,412	$ 27,906,412	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,278,647	$ 32,278,647	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 28,388,980	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 28,388,980	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(442,991)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	(14,934)	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**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (457,925)	17
	B. Transfers (Itemize):		
18	**Transfers out of Restricted Funds into Operations- exp.**	(24,643)	18
19	**Transfers out of Restricted Funds into Operations-capital**	(208,815)	19
20	**Transfers into Operations from Restricted Funds**	208,815	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (24,643)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 27,906,412	24 *

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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	$ 2,278,571	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,278,571	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	37,310	5
6	Therapy		6
7	Oxygen	18,435	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,745	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	128,856	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 128,856	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)**	$ 2,463,172	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	302,619	31
32	Health Care	1,348,603	32
33	General Administration	552,065	33
	B. Capital Expense		
34	Ownership	576,718	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	126,158	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,906,163	40
41	**Income before Income Taxes (line 30 minus line 40)****	(442,991)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (442,991)	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: 07/01/10 Ending: 06/30/11

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	$ 69,992	$ 33.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,875	17,763	552,244	31.09	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	28,790	30,305	403,001	13.30	5
6	CNA Trainees					6
7	Licensed Therapist	1,126	1,186	38,876	32.78	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	7,015	7,384	69,120	9.36	18
19	Laundry	2,569	2,704	27,231	10.07	19
20	Administrator	1,976	2,080	79,997	38.46	20
21	Assistant Administrator					21
22	Other Administrative	1,482	1,560	36,520	23.41	22
23	Office Manager					23
24	Clerical	2,766	2,912	32,847	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	35,360	17.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	198	208	2,600	12.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,404	74,110	$ 1,399,754 *	$ 18.89	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	94	$ 4,714	1	35
36	Medical Director	monthly	26,280	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	878	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	49	1,701	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	5	383	15	46
47	Vision	0	0	15	47
48	Dental	34	850	15	48
49	TOTAL (lines 35 - 48)	182	$ 34,806		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	505	$ 29,542	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	381	10,175	10	52
53	TOTAL (lines 50 - 52)	886	$ 39,717		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lois Kramer	Administrator		$ 79,997
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,997

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	$ 6,259
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,259

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,569
Unemployment Compensation Insurance	8,572
FICA Taxes	107,081
Employee Health Insurance	78,995
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	20,036
Dental	7,872
Life Insurance	725
Long Term Disability	491
TOTAL (agree to Schedule V, line 22, col.8)	$ 252,341

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,448
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues/subscriptions	996
IHCA Dues	1,101
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,545

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/10 Ending: 06/30/11

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:** 07/01/10 **Ending:** 06/30/11

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 $1337**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,907** 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. $ **126,158**
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 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