FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Childrens Home

Address: 164 S 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
IRS Exemption Code 501 (c) 3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: 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 07/01/15 to 06/30/16 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) CEO/President

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	21	Skilled Pediatric (SNF/PED)	21	7,686	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	21	TOTALS	21	7,686	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	7,397	11		7,408	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,397	11		7,408	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.38%

D. How many bed-hold days during this year were paid by the Department?
13 (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 [ ] NO [ ]

Tax Year: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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		621	4,638	5,259		5,259		5,259			1
2	Food Purchase		43,525		43,525		43,525		43,525			2
3	Housekeeping	81,962	11,237	193	93,393		93,393		93,393			3
4	Laundry	27,231	5,375		32,606		32,606		32,606			4
5	Heat and Other Utilities			62,346	62,346		62,346		62,346			5
6	Maintenance	42,704	5,989	41,071	89,764		89,764		89,764			6
7	Other (specify):* Disposal Services			5,852	5,852		5,852		5,852			7
8	TOTAL General Services	151,898	66,747	114,100	332,744		332,744		332,744			8
	B. Health Care and Programs											
9	Medical Director			27,484	27,484		27,484		27,484			9
10	Nursing and Medical Records	1,076,375	145,431	63,098	1,284,904	(835,246)	449,658		449,658			10
10a	Therapy	78,430	584	2,163	81,177		81,177		81,177			10a
11	Activities	21,740	7,119	62	28,920		28,920		28,920			11
12	Social Services	6,660			6,660		6,660		6,660			12
13	CNA Training											13
14	Program Transportation	6,427		32,815	39,242		39,242		39,242			14
15	Other (specify):* Vision, Dental,Pharmacy & Pysch consultants			3,851	3,851		3,851		3,851			15
16	TOTAL Health Care and Programs	1,189,632	153,134	129,472	1,472,238	(835,246)	636,992		636,992			16
	C. General Administration											
17	Administrative	94,494			94,494		94,494		94,494			17
18	Directors Fees											18
19	Professional Services			11,460	11,460		11,460		11,460			19
20	Dues, Fees, Subscriptions & Promotions			16,721	16,721		16,721	(5,609)	11,112			20
21	Clerical & General Office Expenses	46,458	49,475	15,660	111,594	(12,588)	99,006		99,006			21
22	Employee Benefits & Payroll Taxes			332,453	332,453		332,453		332,453			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,674	4,674		4,674	(4,674)	0			24
25	Other Admin. Staff Transportation			7,968	7,968		7,968	(7,968)	0			25
26	Insurance-Prop.Liab.Malpractice			40,309	40,309		40,309		40,309			26
27	Other (specify):* fund-raising/promotional)			2,500	2,500		2,500	(2,500)				27
28	TOTAL General Administration	140,953	49,475	431,746	622,174	(12,588)	609,586	(20,751)	588,835			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,482,483	269,356	675,318	2,427,157	(847,834)	1,579,323	(20,751)	1,558,572			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 Childrens Home #0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			242,192	242,192		242,192	(11,018)	231,174			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,584	1,584		1,584	(1,584)	0			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			16,560	16,560		16,560	(16,560)	(0)			34
35	Rent-Equipment & Vehicles					12,588	12,588		12,588			35
36	Other (specify):*											36
37	**TOTAL Ownership**			260,336	260,336	12,588	272,924	(29,162)	243,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					835,246	835,246		835,246			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,126	138,126		138,126		138,126			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			138,126	138,126	835,246	973,372		973,372			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,482,483	269,356	1,073,780	2,825,619		2,825,619	(49,913)	2,775,706			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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(1,584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,609)	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				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	(40,220)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,913)		$	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))**	$ (49,913)		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 Childrens Home

ID# 0011288

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (4,674)	24	1
2	Travel & Sustenance	(7,968)	25	2
3	Depreciation	(11,018)	30	3
4	Rent	(16,560)	34	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**	(40,220)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Childrens Home **#** 0011288 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,609)	0	0	0	0	0	0	0	0	0	0	(5,609)	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	(4,674)	0	0	0	0	0	0	0	0	0	0	(4,674)	24
25	Other Admin. Staff Transportation	(7,968)	0	0	0	0	0	0	0	0	0	0	(7,968)	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**	(20,751)	0	0	0	0	0	0	0	0	0	0	(20,751)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,751)	0	0	0	0	0	0	0	0	0	0	(20,751)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Childrens Home # 0011288 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,018)	0	0	0	0	0	0	0	0	0	0	(11,018)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,584)	0	0	0	0	0	0	0	0	0	0	(1,584)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(16,560)	0	0	0	0	0	0	0	0	0	0	(16,560)	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**	(29,162)	0	0	0	0	0	0	0	0	0	0	(29,162)	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)**	(49,913)	0	0	0	0	0	0	0	0	0	0	(49,913)	45

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 [X] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 [X] 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	Dietary	Direct Cost Budget	15,991,092	15,991,092	$ 8	$	2,596,177	$ 1	1
2	2	Food	Direct Cost Budget	15,991,092	15,991,092	1,033		2,596,177	168	2
3	3	Housekeeping	Direct Cost Budget	15,991,092	15,991,092	5,856		2,596,177	951	3
4	5	Utilities	Direct Cost Budget	15,991,092	15,991,092	52,741		2,596,177	8,563	4
5	6	Maintenance	Direct Cost Budget	15,991,092	15,991,092	16,445		2,596,177	2,670	5
6	7	Disposal	Direct Cost Budget	15,991,092	15,991,092	3,476		2,596,177	564	6
7	13	BNATP	Direct Cost Budget	15,991,092	15,991,092	0		2,596,177	0	7
8	14	Transportation	Direct Cost Budget	15,991,092	15,991,092	5,672		2,596,177	921	8
9	19	Professional Services	Direct Cost Budget	15,991,092	15,991,092	58,590		2,596,177	9,512	9
10	20	Fees,Subscription	Direct Cost Budget	15,991,092	15,991,092	60,531		2,596,177	9,827	10
11	21	Clerical/Office	Direct Cost Budget	15,991,092	15,991,092	202,404		2,596,177	32,861	11
12	22	Benefits	Direct Cost Budget	15,991,092	15,991,092	66,810		2,596,177	10,847	12
13	24	Travel & Seminar	Direct Cost Budget	15,991,092	15,991,092	11,757		2,596,177	1,909	13
14	25	Staff Transportation	Direct Cost Budget	15,991,092	15,991,092	7,592		2,596,177	1,233	14
15	26	Insurance	Direct Cost Budget	15,991,092	15,991,092	20,945		2,596,177	3,400	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 513,861	$		$ 83,427	25

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

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

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

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Childrens 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-14-301-031	Residential - Tax exempt	$	$
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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).

Marklund Day School

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	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			1999	300		5			300	9
10	LI Parking Lot Concrete Asphalt			1999	32,199		5			32,199	10
11	LI Parking Lot Concrete Asphalt			2000	300		5			300	11
12	LI Resurface Playground			2000	7,750		5			7,750	12
13	LI Safety Surfacing			2000	6,094		5			6,094	13
14	LI Landscaping of Playground			2000	3,325		5			3,325	14
15	BI Awnings Rear Entrance			2000	2,023		5			2,023	15
16	BI Lower Level Classroom Renovatons			2000	183		5			183	16
17	BI Awning for Oxygen 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 Renovatons			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		48,077	23
24	BI ineterior design, handrails, corner pieces			1999	29,873		15			29,873	24
25	BI demolition old lwer 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 walla			1999	101,713		10			101,713	28
29	BI cabinets			1999	46,002		15			46,002	29
30	BI reg. & ato doors			1999	18,259		10			18,259	30
31	BI electrical work lower level			1999	29,697		10			29,697	31
32	BI window shutters			1999	15,529		10			15,529	32
33	BI floor/carpeting			1999	46,503		5			46,503	33
34	BI signage-nterior/exterior			1999	3,899		10			3,899	34
35	BI plumbiong lower level			1999	21,177	1,059	20	1,059		17,471	35
36	ECU awnings			1999	3,994		15			3,994	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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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		15			11,010	38
39	BI new door hardware	1999	197		10			197	39
40	BI fire alarm system upper level	1999	12,491	500	25	500		8,244	40
41	BI water heater	2001	767		5			767	41
42	BI air curtain	2001	764		5			764	42
43	BI replacem,ent parts- boiler	2001	3,858		5			3,858	43
44	BI compressor pump	2001	1,599		5			1,599	44
45	BI scurity 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		15			2,580	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 gernerator	2001	3,002		5			3,002	50
51	BI sliding soor 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 caoncrete pads for oxygen , chllert, and garbage	2002	15,571		5			15,571	54
55	BI renovations; architect, engineering, reconstruciton	2005	2,571,858		10			2,571,858	55
56	BI renovations: electrcial work	2005	65,707		10			65,707	56
57	BI renovations: pipimg and plumbing	2005	114,194		10			114,194	57
58	BI renovations: shelving	2005	1,118		10			1,118	58
59	BI hot water heater	2005	4,529		5			4,529	59
60	lanscaping: plants, flowers, bushers	2005	4,055		5			4,055	60
61	LI outdoor lighting	2005	38,190		10			38,190	61
62	LI exterior signage	2006	5,380		5			5,380	62
63	BI dugout walls w/door and jams	2006	13,671		5			13,671	63
64	BI roof removal and replacement	2006	62,340	3,117	10	3,117		62,340	64
65	BI fire door w/metal edge astragals w/door coordinators	2006	1,730		5			1,730	65
66	BI HVAC roof repairs	2006	69,022	3,451	10	3,451		69,022	66
67	BI electrical work for HVAC	2006	3,900		5			3,900	67
68	BI asbestos tile and mastic removal -exercise room	2006	2,950		5			2,950	68
69	BI painting of 4 bedrooms	2006	3,875		5			3,875	69
70	TOTAL (lines 4 thru 69)		$ 3,671,266	$ 11,040		$ 11,040	$	$ 3,638,547	70

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 11,040		$ 11,040	$	$ 3,638,547	1
2	LI tree removal/gravel/move shed-campsite	2007	1,150		5			1,150	2
3	LI campus signs	2007	5,380		5			5,380	3
4	BI new carpeting /room 3	2007	4,420		5			4,420	4
5	BI asbestos consulting and removal	2007	2,614		3			2,614	5
6	BI sprinklers for awniongs	2008	2,400		5			2,400	6
7	BI awnings	2008	7,826		5			7,826	7
8	BI boiler repair	2008	2,925		3			2,925	8
9	BI electrical resceptacles in wiremold	2008	3,645		5			3,645	9
10	LI sidewalk repair	2008	3,300		5			3,300	10
11	LI peace ole garden	2009	2,837		5			2,837	11
12	BI insulate windows /re-install trim	2009	858		5			858	12
13	BI installaton of wiremold outlets	2009	1,036		5			1,036	13
14	BI carpeting amd installation in office area	2009	5,500		5			5,500	14
15	BI labor/material - water main repair	2009	2,860		5			2,860	15
16	BI tie doors into fire system	2009	1,695		5			1,695	16
17	LI driveway reconstructiu	2010	88,608	8,394	10	8,394		59,227	17
18	LI (2) 10"-12" spruce trees	2010	4,375		5			4,375	18
19	LI trash enclosure w/ornamental fencing	2010	6,295		5			6,295	19
20	LI earthwork	2010	33,414	3,166	10	3,166		22,335	20
21	LI faences and gates	2010	2,310		5			2,310	21
22	LI sealcoating and striping of driveway	2010	2,451		2			2,451	22
23	LI trees, shrubs, miisc planting	2010	10,240		5			10,240	23
24	LI (4) fat albert colorado spruce trees	2010	1,660		5			1,660	24
25	BI gutter replacement	2010	1,592		5			1,592	25
26	BI construction: plumbing for dental lines	2010	143,610	6,996	20	6,996		49,159	26
27	BI demo: bldg, flooring, masonry, alarm service	2010	75,010	3,654	20	3,654		25,676	27
28	BI construction: drywall, painting, insulation	2010	98,198	4,784	20	4,784		33,614	28
29	BI contruction: skylights,door frames, emntrances	2010	111,060	5,411	20	5,411		38,017	29
30	BI architect, plands, surveys, conults	2010	171,381	8,349	20	8,349		58,665	30
31	BI costrcutuon: structural engeeting consults/plan reviews	2010	72,963	3,555	20	3,555		24,976	31
32	BI constrcutiion: damproofing/water protection	2010	7,275	728	10	728		4,729	32
33	BI electrical work	2010	282,582	13,767	20	13,767		96,730	33
34	TOTAL (lines 1 thru 33)		$ 4,832,736	$ 69,844		$ 69,844	$	$ 4,129,044	34

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 69,844		$ 69,844	$	$ 4,129,044	1
2	BI Construction: Masonry,concrete, steel, roofing	2010	238,586	11,623	20	11,623		81,670	2
3	BI installation: blinds and shades	2010	10,054	1,005	10	1,005		6,535	3
4	BI constrcution: vinyl flooring, carpeting	2010	60,995	6,100	10	6,100		39,647	4
5	BI construction: general conditions	2010	330,889	16,120	20	16,120		113,266	5
6	BI installation of cabinetry	2010	1,990	199	10	199		1,294	6
7	BI constrction: heating, ventilation, elevator	2010	335,130	16,327	20	16,327		114,718	7
8	BI air testing, monitoring, reporting	2010	3,420	342	10	342		2,223	8
9	BI construction fire protection system	2010	85,492	8,549	10	8,549		55,570	9
10	BI construction: carpentry	2010	341,102	16,618	20	16,618		116,762	10
11	BI connect back up phone, door	2010	4,800		5			4,800	11
12	BI tuckpointing/restoration to chimney stack	2010	3,475		5			3,475	12
13	LI 12" drain.drain tile connect culvert to server	2011	5,070	507	5	507		5,070	13
14	LI gable style awing over oxygen storage	2011	1,296	130	5	130		1,296	14
15	BI hot water heater	2011	1,753	175	5	175		1,753	15
16	BI gutter and sownspout repairs	2011	1,220	122	5	122		1,220	16
17	BI repalcement of wall carpeting	2011	2,980	298	5	298		2,980	17
18	BI exterior handrail	2012	1,250	250	5	250		1,125	18
19	LI refurbishing of exterior signs	2012	6,100	1,220	5	1,220		5,490	19
20	LI asphalt repairs to driveweay	2012	825	165	5	165		743	20
21	LI lanscaping: installation of catch basin drainnage	2012	4,535	907	5	907		4,082	21
22	BI surge suppression system	2013	2,583	517	5	517		1,808	22
23	LI 220 LF of barrier curb	2013	7,902	790	5	790		2,766	23
24	LI 70 SF unilock stack stone split	2013	3,780	756	5	756		2,646	24
25	BI rubber floor replacement	2014	624	125	5	125		312	25
26	BI HM replacement door set	2014	2,883	577	5	577		1,441	26
27	BI installation of bi-fold door	2015	1,925	385	5	385		578	27
28	LI refurbish/revise outdoor sign	2015	2,467	493	5	493		740	28
29	LI sidewalk/dumpster pad /ADA ramps/concrete	2015	12,200	1,220	10	1,220		1,830	29
30	LI concrete walk to connect tp park distrcit	2015	1,050	105	10	105		158	30
31	LI asphalt driveway renovation	2015	60,950	6,095	10	6,095		9,143	31
32	LI sidewalk railings	2015	1,450	145	10	145		218	32
33	BI flooring replacement (pod 1)	2016	8,850	443	10	443		443	33
34	TOTAL (lines 1 thru 33)		$ 6,380,360	$ 162,151		$ 162,151	$	$ 4,714,840	34

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 12C, Carried Forward		$ 6,380,360	$ 162,151		$ 162,151	$	$ 4,714,840	1
2	BI Ladder for elevator pit	2016	9,726	49	10	49		49	2
3	BI repainting of roof	2016	11,925	596	10	596		596	3
4	BI install swer pipe installation/remove & replace hydrant	2016	5,344	534	5	534		534	4
5	LI reoair existing concrete retaining wall	2016	2,178	54	20	54		54	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,409,533	$ 163,385		$ 163,385	$	$ 4,716,074	34

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 313,945	$ 51,417	$ 51,417	$		$ 163,811	71
72	Current Year Purchases	33,568	3,995	3,995			3,995	72
73	Fully Depreciated Assets	827,128					840,907	73
74								74
75	TOTALS	$ 1,174,641	$ 55,412	$ 55,412	$		$ 1,008,713	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	2012 F-250 Box Truck	2012	$ 38,315	$ 7,774	$ 7,774	$	5	$ 34,427	76
77	Patient Transport	2006 Ford El Dorado Bus	2006	48,480					48,480	77
78	Courier	2013 Ford TraNSIT Connect	2013	23,020	4,604	4,604			16,114	78
79	Patient Transport	2009 Ford Mobility van	2009	34,475					34,475	79
80	TOTALS			$ 144,290	$ 12,378	$ 12,378	$		$ 133,497	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)	$ 7,759,964	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 231,174	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 231,174	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,858,283	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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 12,588 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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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			0				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 Programs		25644	692,389			142,857	25,644	835,246	12
13	Other (specify):									13
14	TOTAL			$ 692,389		$	$ 142,857	25,644	$ 835,246	14

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

Facility Name & ID Number Marklund Childrens Home **#** 0011288 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/16 **(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	$ 842,189	$ 842,189	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 246,500)	2,639,956	2,639,956	3
4	Supply Inventory (priced at)	81,185	81,185	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	180,974	180,974	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): client related accounts	667,714	667,714	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,412,018	$ 4,412,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,865,917	6,865,917	13
14	Buildings, at Historical Cost	25,506,038	25,506,038	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,270,044	6,270,044	16
17	Accumulated Depreciation (book methods)	(21,543,200)	(21,543,200)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,916,012	6,916,012	21
22	Other Long-Term Assets (specify):	5,393,729	5,393,729	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 29,408,540	$ 29,408,540	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 33,820,558	$ 33,820,558	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 262,582	$ 262,582	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	312,358	312,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,052	24,052	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	compensation & related payables	(184,258)	(184,258)	36
37	misc. other	1,480,580	1,480,580	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,895,314	$ 1,895,314	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)**	$ 1,895,314	$ 1,895,314	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,925,244	$ 31,925,244	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 33,820,558	$ 33,820,558	48

***(See instructions.)**

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 32,962,877	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,962,877	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(160,625)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	839,788	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**	(2,653,774)	15
16	Other (describe) **loss on disposal of building & equipment**	8,192	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,966,419)	17
	B. Transfers (Itemize):		
18	**Transfers out of Restricted Funds into Operations- exp.**	928,786	18
19	**Transfers out of Restricted Funds into Operations-capital**	290,306	19
20	**Transfers into Operations from Restricted Funds**	(290,306)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 928,786	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,925,244	24 *

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,402,657	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,402,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,001	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,001	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,404,658	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	332,744	31
32	Health Care	1,472,238	32
33	General Administration	622,174	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	138,126	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,565,283	40
41	**Income before Income Taxes (line 30 minus line 40)****	(160,625)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (160,625)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,398,179	44
45	Private Pay - Net Inpatient Revenue	4,478	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,402,657	49

* **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 Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 86,528	$ 41.60	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	17,863	18,803	507,686	27.00	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	28,790	30,306	442,765	14.61	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	2,016	2,122	72,431	34.14	7
8	Rehab/Therapy Aides	395	416	5,999	14.42	8
9	Activity Director	0	0	0		9
10	Activity Assistants	1,482	1,560	21,740	13.94	10
11	Social Service Workers	395	416	6,660	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,383	1,456	42,704	29.33	17
18	Housekeepers	7,015	7,384	81,962	11.10	18
19	Laundry	2,569	2,704	27,231	10.07	19
20	Administrator	1,976	2,080	94,494	45.43	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	20	21	1,177	56.57	22
23	Office Manager	0	0	0		23
24	Clerical	2,766	2,912	45,282	15.55	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,976	2,080	35,069	16.86	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	316	333	4,326	13.00	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	71,432	75,192	$ 1,482,483 *	$ 19.72	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	93	$ 4,638	1	35
36	Medical Director	monthly	27,484	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,251	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	varies	2,163	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	10	850	15	46
47	Vision	visit	450	15	47
48	Dental	vist	1,300	15	48
49	TOTAL (lines 35 - 48)	103	$ 38,135		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	612	$ 32,170	10	50
51	Licensed Practical Nurses	612	0	10	51
52	Certified Nurse Assistants/Aides	612	30,928	10	52
53	TOTAL (lines 50 - 52)	1,836	$ 63,098		53

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gunjan Patel	Administrator		$ 94,494
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,494

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	$ 9,512
Robin R Kelleher	legal fees	1,948
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 11,460

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,136
Unemployment Compensation Insurance	11,553
FICA Taxes	113,410
Employee Health Insurance	125,878
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	25,734
Dental	11,078
Life Insurance	2,543
Long Term Disability	121
TOTAL (agree to Schedule V, line 22, col.8)	$ 332,453

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	9,057
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues/subscriptions	857
IHCA Dues	1,197
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,111

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 , $1,197**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **16,389** 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 fo
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 Departmen
during this cost report period. $ **138,126**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

Type	Manufacturer	Model	Qty	Location
Copier	Minolta	BizHub 224E	1	MPC
Copier	Minolta	BizHub C224E	1	
Copier	Minolta	BizHub C454E	1	