FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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) 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
  - [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 07/01/17 to 06/30/18 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 Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	7,665	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	7,665	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	7,288			7,288	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,288			7,288	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.08%

D. How many bed reserve days during this year were paid by the Department?
113 (Do not include bed reserve 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	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

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

Tax Year: 06/30/2018 Fiscal Year: 06/30/2018

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		136	4,671	4,807		4,807		4,807			1
2	Food Purchase		57,652		57,652		57,652		57,652			2
3	Housekeeping	81,962	9,390	19,644	110,996		110,996		110,996			3
4	Laundry	30,014	4,771		34,785		34,785		34,785			4
5	Heat and Other Utilities			56,036	56,036		56,036		56,036			5
6	Maintenance	30,503	5,041	38,923	74,467		74,467		74,467			6
7	Other (specify):* Disposal Services			5,069	5,069		5,069		5,069			7
8	TOTAL General Services	142,480	76,990	124,343	343,812		343,812		343,812			8
	B. Health Care and Programs											
9	Medical Director			27,484	27,484		27,484		27,484			9
10	Nursing and Medical Records	1,065,135	153,568	132,586	1,351,289	(857,646)	493,643		493,643			10
10a	Therapy	132,989	2,013	4,938	139,940		139,940		139,940			10a
11	Activities	31,793	8,025		39,818		39,818		39,818			11
12	Social Services	6,660			6,660		6,660		6,660			12
13	CNA Training											13
14	Program Transportation	6,427		10,455	16,882		16,882		16,882			14
15	Other (specify):* Vision,Dental,Pharmacy & Pysch Consultants			3,782	3,782		3,782		3,782			15
16	TOTAL Health Care and Programs	1,243,004	163,606	179,245	1,585,855	(857,646)	728,209		728,209			16
	C. General Administration											
17	Administrative	94,494			94,494		94,494		94,494			17
18	Directors Fees											18
19	Professional Services			14,525	14,525		14,525		14,525			19
20	Dues, Fees, Subscriptions & Promotions			13,474	13,474		13,474	(394)	13,080			20
21	Clerical & General Office Expenses	90,064	57,732	30,442	178,237	(13,341)	164,896		164,896			21
22	Employee Benefits & Payroll Taxes			383,501	383,501		383,501		383,501			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,835	3,835		3,835	(3,835)	0			24
25	Other Admin. Staff Transportation			8,099	8,099		8,099	(8,099)	(0)			25
26	Insurance-Prop.Liab.Malpractice			30,011	30,011		30,011		30,011			26
27	Other (specify):* Bad Debt			2,500	2,500		2,500	(2,500)				27
28	TOTAL General Administration	184,558	57,732	486,386	728,676	(13,341)	715,335	(14,828)	700,507			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,570,043	298,327	789,974	2,658,344	(870,987)	1,787,357	(14,828)	1,772,529			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: 07/01/17 Ending: 06/30/18

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			219,103	219,103		219,103	(8,509)	210,594			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,416	7,416		7,416	(7,416)	0			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					13,341	13,341		13,341			35
36	Other (specify):*											36
37	**TOTAL Ownership**			226,519	226,519	13,341	239,860	(15,925)	223,935			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					857,646	857,646		857,646			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			139,941	139,941		139,941		139,941			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			139,941	139,941	857,646	997,587		997,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,570,043	298,327	1,156,433	3,024,804		3,024,804	(30,753)	2,994,051			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: 07/01/17 Ending: 06/30/18

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	(7,416)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(394)	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	(20,443)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,753)		$	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))**	$ (30,753)		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: 07/01/17

Ending: 06/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminars	$ (3,835)	24	1
2	Travel & Sustenance	(8,099)	25	2
3	Depreciation	(8,509)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,443)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(394)	0	0	0	0	0	0	0	0	0	0	(394)	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	(3,835)	0	0	0	0	0	0	0	0	0	0	(3,835)	24
25	Other Admin. Staff Transportation	(8,099)	0	0	0	0	0	0	0	0	0	0	(8,099)	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**	(14,828)	0	0	0	0	0	0	0	0	0	0	(14,828)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,828)	0	0	0	0	0	0	0	0	0	0	(14,828)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(8,509)	0	0	0	0	0	0	0	0	0	0	(8,509)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,416)	0	0	0	0	0	0	0	0	0	0	(7,416)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,925)	0	0	0	0	0	0	0	0	0	0	(15,925)	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)**	(30,753)	0	0	0	0	0	0	0	0	0	0	(30,753)	45

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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		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 Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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	24,496,734	24,496,734	$ 0	$	2,829,467	$ 0	1
2	2	Food	Direct Cost Budget	24,496,734	24,496,734	707		2,829,467	82	2
3	3	Housekeeping	Direct Cost Budget	24,496,734	24,496,734	4,077		2,829,467	471	3
4	5	Utilities	Direct Cost Budget	24,496,734	24,496,734	26,257		2,829,467	3,033	4
5	6	Maintenance	Direct Cost Budget	24,496,734	24,496,734	13,396		2,829,467	1,547	5
6	7	Disposal	Direct Cost Budget	24,496,734	24,496,734	1,114		2,829,467	129	6
7	13	BNATP	Direct Cost Budget	24,496,734	24,496,734	0		2,829,467	0	7
8	14	Transportation	Direct Cost Budget	24,496,734	24,496,734	0		2,829,467	0	8
9	19	Professional Services	Direct Cost Budget	24,496,734	24,496,734	92,750		2,829,467	10,713	9
10	20	Fees,Subscription	Direct Cost Budget	24,496,734	24,496,734	78,979		2,829,467	9,122	10
11	21	Clerical/Office	Direct Cost Budget	24,496,734	24,496,734	361,403		2,829,467	41,743	11
12	22	Benefits	Direct Cost Budget	24,496,734	24,496,734	121,293		2,829,467	14,010	12
13	24	Travel & Seminar	Direct Cost Budget	24,496,734	24,496,734	14,043		2,829,467	1,622	13
14	25	Staff Transportation	Direct Cost Budget	24,496,734	24,496,734	9,502		2,829,467	1,098	14
15	26	Insurance	Direct Cost Budget	24,496,734	24,496,734	25,548		2,829,467	2,951	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 749,069	$		$ 86,521	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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: 07/01/17 Ending: 06/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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).		$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 07/01/17 Ending: 06/30/18

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 Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	BI extensive repair (parts/labor)			1998	2,675		5			2,675	9
10	BI Repair Roof, Gutters & Downspt			1999	8,800		5			8,800	10
11	BI Parts & Labor to install new			1999	2,580		15			2,580	11
12	BI FIRE SPRINKLER SYSTEM			1999	72,843	2,914	25	2,914		53,904	12
13	BI LOWER LEVEL CONST. PLUMBING			1999	21,177	1,059	20	1,059		19,589	13
14	BI CABINETS (MATERIAL & INSTALLA)			1999	46,002		15			46,002	14
15	BI EXTERIOR AWNINGS,ECU ENTRANC			1999	3,994		15			3,994	15
16	BI ELEVATOR CONTROLLER & SECURITY SYS			1999	11,010		15			11,010	16
17	BI INTERIOR DESIGN-TRIM,CORNER PCS			1999	29,873		15			29,873	17
18	BI Survey, Architectural,Engineer Constr			1999	49,390		10			49,390	18
19	BI CONTRUCTION-WALLS,CEILINGS			1999	101,713		10			101,713	19
20	BI REGULAR & AUTOMATIC DOORS & PROTECTORS			1999	18,259		10			18,259	20
21	BI ELECTRICAL WORK - LOWER LEVEL			1999	29,697		10			29,697	21
22	BI WINDOWS & SHUTTERS			1999	15,529		10			15,529	22
23	BI MCH CONSTRUCTION-INTERIOR & EXTERIOR BLDG SIGNS			1999	3,899		10			3,899	23
24	BI DEMOLITION-REVOVAL WALLS,TILE CEILING			1999	26,641		10			26,641	24
25	BI MATERIAL & INSTALLATION - OAK CHAIR RAIL & CAP			1999	8,160		5			8,160	25
26	BI PAINTING - RENOVATIONS & LOWER			1999	19,835		5			19,835	26
27	BI CONSTRUCTION-FLOORING & CARPETING			1999	46,503		5			46,503	27
28	BI WALL COVERINGS & PANELING			1999	7,309		5			7,309	28
29	BI DOOR HARDWARE FOR NEW DOOR.			1999	197		10			197	29
30	BI FIRE ALARM SYSTEM FOR UPPER LEVEL			1999	12,491	500	25	500		9,243	30
31	BI FIRE DOORS REQUIRED BY IDPA			1999	564		10			564	31
32	BI LOWER LEVEL CLASSROOM RENOVATI			1999	1,346		5			1,346	32
33	BI FLOORING/CARPET INSTALLATION			1999	5,855		5			5,855	33
34	BI REPL WINDOW PER IDPA INSPECTIO			1999	538		5			538	34
35	LI PARKING LOT CONCRETE/ASHAPLT			1999	32,199		5			32,199	35
36	LI PARKING LOT CONCRETE/ASPHALT			1999	300		5			300	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: 07/01/17 Ending: 06/30/18

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 MICS MATERIALS FOR LOWER LEVE	2000	$ 183	$	5	$	$	$ 183	37
38	BI AWNING FOR REAR ENTERANCE	2000	2,023		5			2,023	38
39	BI AWNING TO PROTECT O2 TANKS	2000	3,477		5			3,477	39
40	BI SECURITY DOOR INCLUDING INSTA-	2000	2,427		5			2,427	40
41	LI PARKING LOT - CONCRETE/ASPHALT	2000	300		5			300	41
42	LI MATERIALS & LABOR FOR RESURFAC	2000	7,750		5			7,750	42
43	LI SAFETY SURFACING OF PLAYGROUND	2000	6,094		5			6,094	43
44	LI LANDSCAPING OF PLAYGROUND	2000	3,325		5			3,325	44
45	BI ADULT AIR CURTAIN	2001	764		5			764	45
46	BI NEW WATER HEATER	2001	767		5			767	46
47	BI Replacement of major parts in	2001	1,047		5			1,047	47
48	BI Compressor Pump Replacement	2001	1,599		5			1,599	48
49	BI Boiler Replacement Parts/Blowr	2001	2,811		5			2,811	49
50	BI Stairwell Door Replacement	2001	1,165		5			1,165	50
51	BI New Radiator+Install in Gener-	2001	3,002		5			3,002	51
52	BI Drive kit for auto sliding	2002	4,179		5			4,179	52
53	BI Flotex Accent carpeting for	2002	1,690		5			1,690	53
54	BI Awning for O2 Concrete Pad	2002	2,694		5			2,694	54
55	LI Concrete pad for garbage	2002	1,100		5			1,100	55
56	LI Concrete pad for O2	2002	3,204		5			3,204	56
57	LI Chiller concrete pad 649sq Ft	2002	4,900		5			4,900	57
58	LI Fencing for for O2 and chiller	2002	2,927		5			2,927	58
59	LI Oxygen storage area Grading	2002	3,440		5			3,440	59
60	BI Hot Water Heater	2004	4,529		5			4,529	60
61	BI MCH Renov: Shelvings	2005	1,118		10			1,118	61
62	BI MCH Renov: Electrical Work	2005	65,707		10			65,707	62
63	BI MCH Renov: Piping & Plumbing	2005	114,194		10			114,194	63
64	BI MCH Renov: Arch /Eng/Recon	2005	2,571,858		10			2,571,858	64
65	BI Painting of 4 bedrooms	2005	3,875		5			3,875	65
66	LI Lndscpng-plant flowers, bushes	2005	4,055		5			4,055	66
67	LI MCH Renov: Light/Fenc/Lanscp	2005	38,190		10			38,190	67
68	BI Roof Removal & Replacement	2006	62,340		10			62,340	68
69	BI Dugout Walls w/ doors & jams	2006	13,671		5			13,671	69
70	TOTAL (lines 4 thru 69)		$ 3,588,284	$ 4,473		$ 4,473	$	$ 3,564,509	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: 07/01/17 Ending: 06/30/18

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		$ 3,588,284	$ 4,473		$ 4,473	$	$ 3,564,509	1
2	BI HVAC Roof Repairs	2006	69,022		10			69,022	2
3	BI Fire Door Metal Edge Astragals	2006	1,730		5			1,730	3
4	BI Electrical Work due to HVAC	2006	3,900		5			3,900	4
5	BI REMOVAL ASBESTOS TILE/MASTIC	2006	2,950		5			2,950	5
6	BI NEW CARPETING AND BASE ROOM 3	2006	4,420		5			4,420	6
7	BI Asbestos Consulting/Removal	2006	2,614		3			2,614	7
8	LI EXTERIOR SIGNAGE	2006	5,380		5			5,380	8
9	LI MCH Campus signs	2006	5,380		5			5,380	9
10	BI ELECTRIC RECEPTACLES IN WIR	2007	3,645		5			3,645	10
11	BI BOILER REPAIR	2007	2,925		3			2,925	11
12	LI Tree removal/gravel/move shed	2007	1,150		5			1,150	12
13	LI SIDEWALK REPAIR	2007	3,300		5			3,300	13
14	BI SPRINKLER INSTALLATION UNDER	2008	2,400		5			2,400	14
15	BI 2 AWNINGS	2008	7,826		5			7,826	15
16	BI LABOR/MATERIAL WATER MAIN	2008	2,860		5			2,860	16
17	BI FURNISH/INSTALLATION OF CARPET	2008	5,500		5			5,500	17
18	BI Insulate Windows/Reinstall	2009	858		5			858	18
19	BI INSTALLATION OF WIREMOLD	2009	1,036		5			1,036	19
20	BI Tie doors into fire system	2009	1,695		5			1,695	20
21	BI Tuckpointing/Restoration	2009	3,475		5			3,475	21
22	LI Peace Pole Garden: Peace Pole	2009	2,837		5			2,837	22
23	LI Trees, Shrubs, Misc Plantings	2009	10,240		5			10,240	23
24	LI 4 Fat Albert Colorado Blue	2009	1,660		5			1,660	24
25	BI Gutter Replacement	2010	1,592		5			1,592	25
26	BI CONSTRUCTION: DAMPROOFING/	2010	7,275	728	10	728		6,184	26
27	BI CONSTRUCTION: BLINDS,SHADES	2010	10,054	1,005	10	1,005		8,545	27
28	BI Construction - Carpentry	2010	341,102	16,618	20	16,618		149,997	28
29	BI Structural/Engineer Consults	2010	72,963	3,555	20	3,555		32,085	29
30	BI Demo/ Bldg, Flooring, Masonry	2010	75,010	3,654	20	3,654		32,985	30
31	BI Const/Skylights, Doors, Frames	2010	111,060	5,411	20	5,411		48,838	31
32	BI Const/Plumbing,Dental lines	2010	143,610	6,996	20	6,996		63,152	32
33	BI Architect. Plans, Surveys	2010	171,381	8,349	20	8,349		75,364	33
34	TOTAL (lines 1 thru 33)		$ 4,669,134	$ 50,789		$ 50,789	$	$ 4,130,054	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: 07/01/17 Ending: 06/30/18

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		$ 4,669,134	$ 50,789		$ 50,789	$	$ 4,130,054	1
2	BI CONSTRUCT: MASONRY, CONCRETE	2010	238,587	11,623	20	11,623		104,917	2
3	BI CONSTRUCTION: Electrical Work	2010	282,582	13,767	20	13,767		124,264	3
4	BI CONSTRUCTION: GENERAL CONDIT	2010	330,889	16,120	20	16,120		145,506	4
5	BI CONSTRCTION: HEATING/VENTIL	2010	335,130	16,327	20	16,327		147,371	5
6	BI Construct/Dryall , painting	2010	98,198	4,784	20	4,784		43,182	6
7	BI CONSTRUCTION: INSTALLATON OF	2010	1,990	199	10	199		1,692	7
8	BI AIR TESTING, MONITORING	2010	3,420	342	10	342		2,907	8
9	BI CONSTRUCTION: VINYL FLOORING	2010	60,995	6,100	10	6,100		51,846	9
10	BI CONSTRUCTION: FIRE PROTECTION	2010	85,492	8,549	10	8,549		72,668	10
11	BI CONNECT BACK-UP-PHONE,DOORS	2010	4,800		5			4,800	11
12	LI EARTHWORK	2010	33,414	3,166	10	3,166		28,666	12
13	LI DRIVEWAY RECONSTRUCTION	2010	88,608	8,394	10	8,394		76,016	13
14	LI FENCES AND GATES	2010	2,310		5			2,310	14
15	LI 5 10'-12' SPRUCE TREES	2010	4,375		5			4,375	15
16	LI TRASH ENCLOSURE W/ORNAMENTAL	2010	6,295		5			6,295	16
17	LI SEALCOATING AND STRIPING OF	2010	2,451		2			2,451	17
18	LI 12" DRAIN, DRAIN TILE CONNECT	2010	5,070		5			5,070	18
19	LI GABLE STYLE AWNING OVER OXYGEN	2010	1,296		5			1,296	19
20	BI HOT WATER HEATER SPLIT W/MDS	2011	1,753		5			1,753	20
21	BI Gutter & Downspout Repairs	2011	1,220		5			1,220	21
22	BI Replacement of Wall Carpeting	2011	2,980		5			2,980	22
23	BI Exterior Handrail	2011	1,250		5			1,250	23
24	LI Landscaping & installation	2011	4,535		5			4,535	24
25	BI Surge Suppression System	2012	2,583	258	5	258		2,583	25
26	LI REFURBISHING OF EXTERIOR SIGNS	2012	6,100		5			6,100	26
27	LI ASPHALT REPAIRS TO DRIVEWAY	2012	825		5			825	27
28	LI 220 LF of 6"Barrier Curb	2012	7,902	790	10	790		4,346	28
29	LI 70 SF Unilock Stack Stone splt	2012	3,780	378	5	378		3,780	29
30	BI HM REPLACEMENT DOOR SET	2013	2,883	577	5	577		2,594	30
31	BI Rubber Flooring Replacement	2014	624	125	5	125		562	31
32	BI Installation of Bi-Fold Door	2014	1,925	385	5	385		1,348	32
33	LI Concrete Walk to Connect	2014	1,050	105	10	105		368	33
34	TOTAL (lines 1 thru 33)		$ 6,294,446	$ 142,778		$ 142,778	$	$ 4,989,930	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: 07/01/17 Ending: 06/30/18

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		$ 6,294,446	$ 142,778		$ 142,778	$	$ 4,989,930	1
2	LI Sidewalk, Dumpster pad, ADA	2014	12,200	1,220	10	1,220		4,270	2
3	LI Asphalt Driveway Renovation	2014	60,950	6,095	10	6,095		21,333	3
4	LI Sidewalk Railings	2014	1,450	145	10	145		508	4
5	BI Ladder for Elevator Pit	2015	973	97	10	97		243	5
6	BI Repainting Roof MPC	2015	11,925	1,193	10	1,193		2,981	6
7	BI Rem & Repl Hydrant, Ins Sewer	2015	5,344	1,069	5	1,069		2,672	7
8	LI REFURBISH/REVISE OUTDOOR SIGN	2015	2,467	493	5	493		1,727	8
9	LI Repair Existing Concrete	2015	2,178	109	20	109		272	9
10	BI Flooring Replacement (Pod1)	2016	8,850	885	10	885		2,213	10
11	BI Data Line Install 10 lines 5dp	2016	78	8	10	8		12	11
12	BI Electric Outlet Orient Room &	2016	66	3	20	3		5	12
13	BI CARPETING-NEW ORIENTATION ROOM	2016	288	58	5	58		86	13
14	BI Hand Rail Replacement Exterior	2017	4,250	425	10	425		638	14
15	BI Relocate Outlets Higher Wall	2017	3,900	390	10	390		585	15
16	LI Outdoor New Logo Sign	2017	2,900	121	12	121		121	16
17	BI Wall Protection Areas	2017	3,300	330	5	330		330	17
18	BI Fiber & Cable Install Elevator	2017	791	79	5	79		79	18
19	BI Firestopping Installation	2017	767	38	10	38		38	19
20	BI Outside Lighting Update to LED	2018	2,875	144	10	144		144	20
21	BI Paint Nrt Ent Ped#1 Ceil Bk Rm	2018	3,795	380	5	380		380	21
22	BI Epoxy Floor Janitor's Closet	2018	1,500	150	5	150		150	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)		$ 6,425,293	$ 156,210		$ 156,210	$	$ 5,028,717	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: 07/01/17 Ending: 06/30/18

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	$ 315,718	$ 45,088	$ 45,088	$		$ 217,636	71
72	Current Year Purchases	6,407	733	733			733	72
73	Fully Depreciated Assets	906,439					906,439	73
74								74
75	TOTALS	$ 1,228,564	$ 45,821	$ 45,821	$		$ 1,124,808	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	Patient Transport	2017 Ford El Dorado Bus	2018	$ 62,608	$ 6,261	$ 6,261	$	5	$ 6,261	76
77	Patient Trasnport	2013 Ford Transit Connect	2013	23,020	2,302	2,302		5	23,020	77
78	Patient Transport	2009 Ford Mobility van	2009	34,475					34,475	78
79										79
80	TOTALS			$ 120,103	$ 8,563	$ 8,563	$		$ 63,756	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)	$ 7,805,460	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,594	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 210,594	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)	$ 6,217,281	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: 07/01/17 Ending: 06/30/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 13,341 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: 07/01/17 Ending: 06/30/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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):		22749	704,078			153,568	22,749	857,646	12
13	Other (specify):									13
14	TOTAL			$ 704,078		$	$ 153,568	22,749	$ 857,646	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 Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/18 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,124,430	$ 2,124,430	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 278,000)	3,404,061	3,404,061	3
4	Supply Inventory (priced at)	90,820	90,820	4
5	Short-Term Investments			5
6	Prepaid Insurance	299,013	299,013	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Accounts	189,277	189,277	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,107,601	$ 6,107,601	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,860,586	7,860,586	13
14	Buildings, at Historical Cost	29,243,242	29,243,242	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	7,448,270	7,448,270	16
17	Accumulated Depreciation (book methods)	(24,927,466)	(24,927,466)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,874,316	7,874,316	21
22	Other Long-Term Assets (specify):	8,264,166	8,264,166	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,763,114	$ 35,763,114	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 41,870,715	$ 41,870,715	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 268,199	$ 268,199	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	152,090	152,090	29
30	Accrued Salaries Payable	626,515	626,515	30
31	Accrued Taxes Payable (excluding real estate taxes)	47,192	47,192	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	27,362	27,362	36
37	Misc. Other	1,062,274	1,062,274	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,183,632	$ 2,183,632	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	834,111	834,111	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)**	$ 834,111	$ 834,111	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,017,743	$ 3,017,743	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 38,852,972	$ 38,852,972	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 41,870,715	$ 41,870,715	48

***(See instructions.)**

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 37,509,804	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 37,509,804	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(642,790)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,720,432	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Remaining Consolidated Income**	(958,315)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 119,327	17
	B. Transfers (Itemize):		
18	**Transfers out of Restricted Funds into Operations- Exp.**	1,223,840	18
19	**Transfers out of Restricted Funds into Operations-Capital**	1,095,562	19
20	**Transfers into Operations from Restricted Funds**	(1,095,562)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,223,841	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 38,852,972	24 *

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	$ 2,257,488	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,257,488	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	3,780	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)**	$ 3,780	23
	D. Non-Operating Revenue		
24	Contributions	120,746	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 120,746	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)**	$ 2,382,014	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	343,812	31
32	Health Care	1,585,855	32
33	General Administration	728,676	33
	B. Capital Expense		
34	Ownership	226,519	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	139,941	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,024,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	(642,790)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (642,790)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,257,488	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,257,488	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 Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	1,778	1,872	$ 74,693	$ 39.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,634	19,614	515,859	26.30	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	28,790	30,306	435,188	14.36	5
6	CNA Trainees					6
7	Licensed Therapist	2,964	3,120	126,391	40.51	7
8	Rehab/Therapy Aides	395	416	6,598	15.86	8
9	Activity Director	395	416	7,800	18.75	9
10	Activity Assistants	1,482	1,560	23,993	15.38	10
11	Social Service Workers	395	416	6,660	16.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	988	1,040	30,503	29.33	17
18	Housekeepers	7,015	7,384	81,962	11.10	18
19	Laundry	2,569	2,704	30,014	11.10	19
20	Administrator	1,976	2,080	94,494	45.43	20
21	Assistant Administrator					21
22	Other Administrative	198	208	26,000	125.00	22
23	Office Manager					23
24	Clerical	2,766	2,912	64,064	22.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	35,069	16.86	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					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)					33
34	TOTAL (lines 1 - 33)	73,132	76,981	$ 1,570,043 *	$ 20.40	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	70	$ 3,475	1	35
36	Medical Director	Monthly	27,484	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Varies	1,376	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	71	4,938	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	12	1,020	15	46
47	Vision	Visit	386	15	47
48	Dental	Visit	1,000	15	48
49	TOTAL (lines 35 - 48)	152	$ 39,679		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,993	$ 89,666	10	50
51	Licensed Practical Nurses	314	8,792	10	51
52	Certified Nurse Assistants/Aides	1,452	34,128	10	52
53	TOTAL (lines 50 - 52)	3,759	$ 132,586		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	$ 10,713
Robin R Kelleher	Legal Fees	3,812
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 14,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,035
Unemployment Compensation Insurance	11,752
FICA Taxes	120,108
Employee Health Insurance	156,117
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	30,670
Dental	12,568
Life Insurance	3,094
Long Term Disability	158
TOTAL (agree to Schedule V, line 22, col.8)	$ 383,501

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	8,226
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues/subscriptions	3,625
IHCA Dues	1,229
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,080

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.

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 , $1229**

(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. $ **18,251** 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. $ **139,941**
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 othe
times when not in use? **N/A**
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. **YES**
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	