

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 South Prairie Avenue Bloomingdale 60108
Number City 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:

☒ VOLUNTARY, NON-PROFIT
☒ 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 07/01/11 to 06/30/12 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) _____

Paid Preparer

(Signed) President/ CEO _____ (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: 07/01/11 Ending: 06/30/12

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	30	Skilled Pediatric (SNF/PED)	30	10,980	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,980	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	7,004	366	80	7,450	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,004	366	80	7,450	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.85%

D. How many bed-hold days during this year were paid by the Department?

151 (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/AF. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ 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 ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/12 Fiscal Year: 06/30/12

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

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					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary		633	4,288	4,921		4,921		4,921		1
2	Food Purchase		55,609		55,609		55,609		55,609		2
3	Housekeeping	69,120	13,384	17,157	99,661		99,661		99,661		3
4	Laundry	27,231	5,558		32,789		32,789		32,789		4
5	Heat and Other Utilities			55,739	55,739		55,739		55,739		5
6	Maintenance	23,995	6,012	40,335	70,342		70,342		70,342		6
7	Other (specify):* Disposal Services			9,678	9,678		9,678		9,678		7
8	TOTAL General Services	120,346	81,197	127,196	328,739		328,739		328,739		8
	B. Health Care and Programs										
9	Medical Director			27,222	27,222		27,222		27,222		9
10	Nursing and Medical Records	1,035,848	140,661	9,577	1,186,086	(1,106,465)	79,621		79,621		10
10a	Therapy	45,654	546	2,363	48,563		48,563		48,563		10a
11	Activities	21,740	5,823		27,563		27,563		27,563		11
12	Social Services	6,660			6,660		6,660		6,660		12
13	CNA Training										13
14	Program Transportation			24,684	24,684		24,684		24,684		14
15	Other (specify):* Vision, Dental,Pharmacy & Pysch consultants			2,241	2,241		2,241		2,241		15
16	TOTAL Health Care and Programs	1,109,902	147,030	66,088	1,323,020	(1,106,465)	216,555		216,555		16
	C. General Administration										
17	Administrative	94,494			94,494		94,494		94,494		17
18	Directors Fees										18
19	Professional Services			8,472	8,472		8,472		8,472		19
20	Dues, Fees, Subscriptions & Promotions			18,595	18,595		18,595	(7,589)	11,006		20
21	Clerical & General Office Expenses	33,907	46,729	32,378	113,014	(9,680)	103,334		103,334		21
22	Employee Benefits & Payroll Taxes			246,739	246,739		246,739		246,739		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,189	2,189		2,189	(2,189)			24
25	Other Admin. Staff Transportation			4,874	4,874		4,874	(4,874)			25
26	Insurance-Prop.Liab.Malpractice			52,290	52,290		52,290		52,290		26
27	Other (specify):* fundraising/promotional			2,500	2,500		2,500	(2,500)			27
28	TOTAL General Administration	128,401	46,729	368,038	543,168	(9,680)	533,488	(17,152)	516,335		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,358,649	274,956	561,322	2,194,928	(1,116,145)	1,078,782	(17,152)	1,061,630		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			546,686	546,686		546,686	(18,470)	528,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,548	4,548		4,548	(4,548)	0			32
33	Real Estate Taxes			23	23		23	(23)				33
34	Rent-Facility & Grounds			18,047	18,047	9,680	27,727	(18,047)	9,680			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			569,304	569,304	9,680	578,984	(41,088)	537,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,106,465	1,106,465		1,106,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,184	125,184		125,184		125,184			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			125,184	125,184	1,106,465	1,231,649		1,231,649			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,358,649	274,956	1,255,810	2,889,415		2,889,415	(58,241)	2,831,175			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,548)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7,589)	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	(43,604)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,241)		\$	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	2	
		Amount	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
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (58,241)		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	2	3	4	
		Yes	No	Amount	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

Report Period Beginning:

Ending:

ID#0011288

07/01/11

06/30/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Seminars	\$ (2,189)	24	1
2	Travel & Sustenance	(4,874)	25	2
3	Depreciation	(18,470)	30	3
4	Real Estate Taxes	(23)	33	4
5	Rent	(18,047)	34	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(43,604)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	(7,589)	0	0	0	0	0	0	0	0	0	0	(7,589)	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	(2,189)	0	0	0	0	0	0	0	0	0	0	(2,189)	24
25	Other Admin. Staff Transportation	(4,874)	0	0	0	0	0	0	0	0	0	0	(4,874)	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	(17,152)	0	0	0	0	0	0	0	0	0	0	(17,152)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,152)	0	0	0	0	0	0	0	0	0	0	(17,152)	29

Summary B

06/30/12

[illegible]

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES

NO

X

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

()

Fax Number

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	12,890,465	12,890,465	\$ 114	\$	2,584,809	\$ 23	1
2	2	Food	Direct Cost Budget	12,890,465	12,890,465	508		2,584,809	102	2
3	3	Housekeeping	Direct Cost Budget	12,890,465	12,890,465	7,519		2,584,809	1,508	3
4	5	Utilities	Direct Cost Budget	12,890,465	12,890,465	56,535		2,584,809	11,337	4
5	6	Maintenance	Direct Cost Budget	12,890,465	12,890,465	26,304		2,584,809	5,274	5
6	7	Disposal	Direct Cost Budget	12,890,465	12,890,465	10,819		2,584,809	2,169	6
7	13	BNATP	Direct Cost Budget	12,890,465	12,890,465	0		2,584,809	0	7
8	14	Transportation	Direct Cost Budget	12,890,465	12,890,465	5,132		2,584,809	1,029	8
9	19	Professional Services	Direct Cost Budget	12,890,465	12,890,465	33,917		2,584,809	6,801	9
10	20	Fees,Subscriptions	Direct Cost Budget	12,890,465	12,890,465	47,695		2,584,809	9,564	10
11	21	Clerical/Office	Direct Cost Budget	12,890,465	12,890,465	249,973		2,584,809	50,125	11
12	22	Benefits	Direct Cost Budget	12,890,465	12,890,465	45,330		2,584,809	9,090	12
13	24	Travel & Seminar	Direct Cost Budget	12,890,465	12,890,465	3,879		2,584,809	778	13
14	25	Staff Transportation	Direct Cost Budget	12,890,465	12,890,465	9,487		2,584,809	1,902	14
15	26	Insurance	Direct Cost Budget	12,890,465	12,890,465	26,147		2,584,809	5,243	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 523,358	\$		\$ 104,945	25

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 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 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>02-14-301-031</u>	<u>Residential - Tax exempt</u>	<u>\$ None</u>	<u>\$</u>
2.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
3.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
4.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
5.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
TOTALS			<u>\$</u>	<u>\$</u>

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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?

☒ (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?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long Term Care	206,930	1968	\$ 31,500	1
2					2
3	TOTALS	206,930		\$ 31,500	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	30		1968	1953	\$ 68,500	\$	33	\$	\$	68,500
5										
6										
7										
8										
	Improvement Type**									
9	LI	Parking Lot Concrete Asphalt land impr	1999		300		5			300
10	LI	Parking Lot Concrete Asphalt land impr	1999		32,199		5			32,199
11	LI	Parking Lot Concrete Asphalt land impr	2000		300		5			300
12	LI	Resurface Playground land impr	2000		7,750		5			7,750
13	LI	Safety Surfacing of Playground	2000		6,094		5			6,094
14	LI	Landscaping of Playground land impr	2000		3,325		5			3,325
15	BI	Awnings rear entrance	2000		2,023		5			2,023
16	BI	lower level classroom renovations	2000		183		5			183
17	BI	awning for O2 protection	2000		3,477		5			3,477
18	BI	fire doors lower level	2000		564		10			564
19	BI	carpet flooring lower level	1999		5,855		5			5,855
20	BI	lower level classroom renovation	1999		1,346		5			1,346
21	BI	replacement windows	1999		538		5			538
22	BI	Construction, engineering, architect, inspection	1999		49,390		10			49,390
23	BI	fire sprinkler system	1999		72,843	2,914	25	2,914		36,422
24	BI	interior design, handrails, corner pieces	1999		29,873	1,992	15	1,992		24,894
25	BI	Demolition old lower level	1999		26,641		10			26,641
26	BI	Chair rails	1999		8,160		5			8,160
27	BI	Painting lower level	1999		19,835		5			19,835
28	BI	lower level construction walls	1999		101,713		10			101,713
29	BI	cabinets	1999		46,002	3,067	15	3,067		38,335
30	BI	Reg. & auto doors	1999		18,259		10			18,259
31	BI	Electrical work lower level	1999		29,697		10			29,697
32	BI	windows/shutters	1999		15,529		10			15,529
33	BI	Floor/carpeting	1999		46,503		5			46,503
34	BI	Signage Interior/Exterior	1999		3,899		10			3,899
35	BI	Plumbing lower level	1999		21,177	1,059	20	1,059		13,236
36	BI	ECU Awnings	1999		3,994	266	15	266		3,328

*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:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BI Paneling	1999	\$ 7,309	\$	5	\$	\$	\$ 7,309	37
38	BI Security System,Elevator	1999	11,010	734	15	734		9,175	38
39	BI New door hardware	1999	197		10			197	39
40	BI Fire alarm system upper level	1999	12,491	500	25	500		6,246	40
41	BI Water Heater	2001	767		5			767	41
42	BI Air Curtain	2001	764		5			764	42
43	BI Replacement Parts - Boiler	2001	3,858		5			3,858	43
44	BI Compressor Pump	2001	1,599		5			1,599	44
45	BI Security Door	2001	2,427		5			2,427	45
46	BI Roof Repair	1999	8,800		5			8,800	46
47	BI New compressor	1999	2,580	172	15	172		2,322	47
48	BI Boiler	1998	2,675		5			2,675	48
49	BI Stairwell Door replacements	2001	1,165		5			1,165	49
50	BI New Radiator for generator	2001	3,002		5			3,002	50
51	BI Sliding door repair	2002	4,179		5			4,179	51
52	BI Carpeting	2002	1,690		5			1,690	52
53	BI Awning	2002	2,694		5			2,694	53
54	LI Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571		5			15,571	54
55	BI Renovations: Architect, Engineering, reconstruct	2005	2,571,858	257,186	10	257,186		1,928,894	55
56	BI Renovations: Electrical work	2005	65,707	6,571	10	6,571		49,280	56
57	BI Renovations: Piping and Plumbing	2005	114,194	11,419	10	11,419		85,645	57
58	BI Renovations: Shelving	2005	1,118	112	10	112		839	58
59	BI Hot Water Heater	2005	4,529		5			4,529	59
60	LI Landscaping: plants, flowers, bushes	2005	4,055		5			4,055	60
61	LI Outdoor lighting, fencing, landscaping	2005	38,190	3,819	10	3,819		28,643	61
62	LI Exterior signage	2006	5,380		5			5,380	62
63	BI Dugout walls w/doors and jams	2006	13,671		5			13,671	63
64	BI Roof removal and replacement	2006	62,340	6,234	10	6,234		40,521	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	6,902	10	6,902		44,864	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	\$ 302,946		\$ 302,946	\$	\$ 2,861,511	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:

07/01/11

Ending:

06/30/12

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	\$ 302,946		\$ 302,946	\$	\$ 2,861,511	1
2	LI Tree Removal/ Gravel/ Move Shed - Campsite	2007	1,150	115	5	115		1,150	2
3	LI MCH Campus Signs	2007	5,380	538	5	538		5,380	3
4	BI New Carpeting/Base Room 3	2007	4,420	442	5	442		4,420	4
5	BI Asbestos Consulting and Removal	2007	2,614		3			2,614	5
6	BI Sprinklers for Awnings	2008	2,400	480	5	480		2,160	6
7	BI Awnings	2008	7,826	1,565	5	1,565		7,043	7
8	BI Boiler Repair	2008	2,925		3			2,925	8
9	BI Electric Receptacles in Wiremold	2008	3,645	729	5	729		3,281	9
10	LI Sidewalk Repair	2008	3,300	660	5	660		2,970	10
11	LI Peace Pole Garden	2009	2,837	567	5	567		1,986	11
12	BI Insulate Windows / Re-install trim	2009	858	172	5	172		601	12
13	BI Installation of Wiremold Outlets	2009	1,036	207	5	207		725	13
14	BI Carpeting & Installation in Office Area	2009	5,500	1,100	5	1,100		3,850	14
15	BI Labor/ Material - Water Main Repair	2009	2,860	572	5	572		2,002	15
16	BI Tie doors into Fire System	2009	1,695	377	5	377		1,130	16
17	LI Driveway Reconstruction	2010	88,608	8,394	10	8,394		25,650	17
18	LI (2) 10'-12' Spruce Trees	2010	4,375	875	5	875		2,188	18
19	LI Trash enclosure w/ornamental Fencing	2010	6,295	1,259	5	1,259		3,148	19
20	LI Earthwork	2010	33,414	3,166	10	3,166		9,672	20
21	LI Fences and Gates	2010	2,310	462	5	462		1,155	21
22	LI Sealcoating and striping of Driveway	2010	2,451	613	2	613		2,451	22
23	LI Trees, shrubs, misc planting	2010	10,240	2,048	5	2,048		5,120	23
24	LI (4) Fat Albert Colorado Blue Spruce Trees	2010	1,660	332	5	332		830	24
25	BI Gutter replacement	2010	1,592	318	5	318		796	25
26	BI Construction/Plumbing Dental lines	2010	143,610	6,996	20	6,996		21,173	26
27	BI Demo/Bldg, Flooring,Masonry,Alarm service	2010	75,010	3,654	20	3,654		11,059	27
28	BI Const/Drywall, Painting, Insulation	2010	98,198	4,784	20	4,784		14,478	28
29	BI Const/Skylights,Door frames,Entrances	2010	111,060	5,411	20	5,411		16,374	29
30	BI Architect,Plans,Surveys,Consults	2010	171,381	8,349	20	8,349		25,268	30
31	BI Structural/Eng Consults,Plans,Reviews	2010	72,963	3,555	20	3,555		10,757	31
32	BI Constructon:Damproofing/Water Protection	2010	7,275	728	10	728		1,819	32
33	BI Construction Electrical Work	2010	282,582	13,767	20	13,767		41,663	33
34	TOTAL (lines 1 thru 33)		\$ 4,832,736	\$ 375,181		\$ 375,181	\$	\$ 3,097,348	34

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

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	\$ 375,181		\$ 375,181	\$	\$ 3,097,348	1
2	BI Construction:Masonry, Concrete,Steel, Roofing	2010	238,586	11,623	20	11,623		35,176	2
3	BI Installation: Blinds and Shades	2010	10,054	1,005	10	1,005		2,513	3
4	BI Construction:Vinyl Flooring, Carpeting	2010	60,995	6,100	10	6,100		15,249	4
5	BI Construction: Geneal Conditions	2010	330,889	16,120	20	16,120		48,785	5
6	BI Installation of Cabinetry	2010	1,990	199	10	199		498	6
7	BI Construction:Heating,Ventilastion,Elevator	2010	335,130	16,327	20	16,327		49,410	7
8	BI Air Testing, Monitoring, Reporting	2010	3,420	342	10	342		855	8
9	BI Construction: Fire Protection System	2010	85,492	8,549	10	8,549		21,373	9
10	BI Construction:Carpentry	2010	341,102	16,618	20	16,618		50,291	10
11	BI Connect back-up Phone, Door	2010	4,800	960	5	960		2,400	11
12	BI Tuckpointing/Restoration to Chimney Stack	2010	3,475	695	5	695		1,738	12
13	LI 12" Drain, Drain Tile Connect Culvert to Sewer	2011	5,070	1,014	5	1,014		1,521	13
14	LI Gable Style Awning Over Oxygen Storage	2011	1,296	259	5	259		389	14
15	BI Hot Water Heater	2011	1,753	351	5	351		526	15
16	BI Gutter & Downspout Repairs	2011	1,220	244	5	244		366	16
17	BI Replacement of Wall Carpeting	2011	2,980	596	5	596		894	17
18	BI Exterior Handrail	2012	1,250	125	5	125		125	18
19	LI Refurbishing of Exterior Signs	2012	6,100	610	5	610		610	19
20	LI Asphalt Repairs to Driveway	2012	825	83	5	83		83	20
21	LI Landscaping/installation of Catch Basin Drainage	2012	4,535	454	5	454		454	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,273,698	\$ 457,454		\$ 457,454	\$	\$ 3,330,602	34

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

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	\$376,054	\$57,956	\$57,956	\$		\$265,689	71
72	Current Year Purchases	32,223	3,283	3,283			3,283	72
73	Fully Depreciated Assets	513,328					513,328	73
74								74
75	TOTALS	\$921,604	\$61,239	\$61,239	\$		\$782,300	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	Ford E250 Box Truck	2012	\$ 38,315	\$ 3,331	\$ 3,331	\$	5	\$ 3,331	76
77	Patient Transport	2006 Ford Eldorado Bus	2006	48,480	4,848	4,848		5	48,480	77
78	Courier	2007 Ford Focus	2007	13,427	1,343	1,343		5	13,427	78
79										79
80	TOTALS			\$ 100,222	\$ 9,522	\$ 9,522	\$		\$ 65,238	80

E. Summary of Care-Related Assets		1	2	
		Reference	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)	\$ 7,327,024	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 528,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 528,216	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)	\$ 4,178,140	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 9,680
- 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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 503,870	\$ 503,870	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>196,500</u>)	4,547,011	4,547,011	3
4	Supply Inventory (priced at _____)	58,147	58,147	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	116,686	116,686	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	635,356	635,356	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,861,070	\$ 5,861,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,444,979	6,444,979	13
14	Buildings, at Historical Cost	22,651,049	22,651,049	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,736,088	4,736,088	16
17	Accumulated Depreciation (book methods)	(16,757,130)	(16,757,130)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,921,984	6,921,984	21
22	Other Long-Term Assets (specify): _____	4,304,940	4,304,940	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,301,910	\$ 28,301,910	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,162,980	\$ 34,162,980	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 356,675	\$ 356,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	680,000	680,000	29
30	Accrued Salaries Payable	146,133	146,133	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,422	12,422	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	<u>compesation & related payables</u>	888,183	888,183	36
37	<u>misc. other</u>	2,630,041	2,630,041	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,713,454	\$ 4,713,454	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,713,454	\$ 4,713,454	46
47	TOTAL EQUITY(page 18, line 24)	\$ 29,449,526	\$ 29,449,526	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,162,980	\$ 34,162,980	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 28,906,412	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 28,906,412	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(535,199)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,388,390	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	(188,485)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 664,706	17
	B. Transfers (Itemize):		
18	Transfers out of Restricted Funds into Operations- exp.	(121,592)	18
19	Transfers out of Restricted Funds into Operations-capital	(274,689)	19
20	Transfers into Operations from Restricted Funds	274,689	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (121,592)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 29,449,526	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Children's Home# 0011288Report Period Beginning: 07/01/11Ending: 06/30/12

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,268,909	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,268,909	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	11,598	5
6	Therapy		6
7	Oxygen	17,151	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 28,749	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	56,558	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56,558	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)	\$ 2,354,216	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	328,739	31
32	Health Care	1,323,020	32
33	General Administration	543,168	33
B. Capital Expense			
34	Ownership	569,304	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	125,184	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,889,415	40
41	Income before Income Taxes (line 30 minus line 40)**	(535,199)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (535,199)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,155,707	44
45	Private Pay - Net Inpatient Revenue	109,386	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security</u>	3,816	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,268,909	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,080	\$ 73,492	\$ 35.33	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	16,875	17,763	552,244	31.09	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	28,790	30,306	403,001	13.30	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,126	1,186	40,038	33.77	7
8	Rehab/Therapy Aides	395	416	5,616	13.50	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	23,995	16.48	17
18	Housekeepers	7,015	7,384	69,120	9.36	18
19	Laundry	2,569	2,704	27,231	10.07	19
20	Administrator	1,976	2,080	94,494	45.43	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	336	354	18,009	50.93	22
23	Office Manager	0	0	0		23
24	Clerical	2,766	2,912	32,847	11.28	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	36,421	17.51	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	198	208	2,600	12.50	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	69,259	72,904	\$ 1,407,508 *	\$ 19.31	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	86	\$ 4,288	1	35
36	Medical Director	monthly	27,222	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,316	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	68	2,363	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	0	0	15	46
47	Vision	0	0	15	47
48	Dental	37	925	15	48
49	TOTAL (lines 35 - 48)	190	\$ 36,114		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	435	9,577	10	52
53	TOTAL (lines 50 - 52)	435	\$ 9,577		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Lois Sheaffer-Kramer			\$ 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		\$ 6,801
Polsinelli Shugart, PC	legal fees		1,671
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,472
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 27,671
Unemployment Compensation Insurance			8,583
FICA Taxes			103,937
Employee Health Insurance			79,339
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension			18,089
Dental			7,736
Life Insurance			704
Long Term Disability			680
TOTAL (agree to Schedule V, line 22, col.8)			\$ 246,739
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			6,754
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Dues/subscriptions			3,151
IHCA Dues			1,101
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,006
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$

*** Attach copy of IMRF notifications**

****See instructions.**

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 , \$1,101
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 24,020

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 125,184

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

Yes,Sch.8

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

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)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	BizHub C452	1
Copier	Minolta	BizHub C280	1
Copier	Minolta	BizHub 283	1