

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0011288 Facility Name: Marklund Childrens Home Address: 164 S Prairie Avenue, Bloomingdale, 60108 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 501c3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Lynn Melvin Telephone Number: (630) 593 5485

Email Address:

Facility Name & ID Number Marklund Childrens Home

0011288 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	21	Skilled Pediatric (SNF/PED)	21	7,686	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	21	TOTALS	21	7,686	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	6,786			6,786	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,786			6,786	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.29%

D. How many bed reserve days during this year were paid by the Department? 159 (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 ☒

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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		520	3,838	4,358		4,358		4,358			1
2	Food Purchase		51,110		51,110		51,110		51,110			2
3	Housekeeping	90,399	10,222	23,754	124,375		124,375		124,375			3
4	Laundry	45,131	7,731		52,862		52,862		52,862			4
5	Heat and Other Utilities			50,867	50,867		50,867		50,867			5
6	Maintenance	32,806	2,616	40,045	75,467		75,467		75,467			6
7	Other (specify):* Disposal Services			6,712	6,712		6,712		6,712			7
8	TOTAL General Services	168,336	72,199	125,216	365,751		365,751		365,751			8
	B. Health Care and Programs											
9	Medical Director			25,484	25,484		25,484		25,484			9
10	Nursing and Medical Records	1,468,557	156,605	52,495	1,677,657		1,677,657		1,677,657			10
10a	Therapy	127,530	2,863	5,460	135,853		135,853		135,853			10a
11	Activities	34,371	8,197		42,568		42,568		42,568			11
12	Social Services	6,001			6,001		6,001		6,001			12
13	CNA Training		435		435		435		435			13
14	Program Transportation	2,808		4,939	7,747		7,747		7,747			14
15	Other (specify):* Vision,Dental,Pharmacy & Pysch Consultants			6,147	6,147		6,147		6,147			15
16	TOTAL Health Care and Programs	1,639,267	168,100	94,525	1,901,892		1,901,892		1,901,892			16
	C. General Administration											
17	Administrative	50,319			50,319		50,319		50,319			17
18	Directors Fees											18
19	Professional Services			17,492	17,492		17,492	(6,643)	10,849			19
20	Dues, Fees, Subscriptions & Promotions			18,407	18,407		18,407	(5,302)	13,105			20
21	Clerical & General Office Expenses	98,413	54,968	27,067	180,448	(6,922)	173,526		173,526			21
22	Employee Benefits & Payroll Taxes			527,725	527,725		527,725		527,725			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,543	10,543		10,543	(3,413)	7,130			24
25	Other Admin. Staff Transportation			2,643	2,643		2,643	(9,773)	(7,130)			25
26	Insurance-Prop.Liab.Malpractice			37,712	37,712		37,712		37,712			26
27	Other (specify):* Bad Debt			4,078	4,078		4,078	(4,078)				27
28	TOTAL General Administration	148,732	54,968	645,667	849,367	(6,922)	842,445	(29,209)	813,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,956,335	295,267	865,408	3,117,010	(6,922)	3,110,088	(29,209)	3,080,879			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			202,147	202,147		202,147	(2,109)	200,038			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,882	1,882		1,882	(1,882)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					6,922	6,922		6,922			35
36	Other (specify):*											36
37	TOTAL Ownership			204,029	204,029	6,922	210,951	(3,991)	206,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,520	161,520		161,520		161,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			161,520	161,520		161,520		161,520			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,956,335	295,267	1,230,957	3,482,559		3,482,559	(33,200)	3,449,359			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,882)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,235)	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	(6,643)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,078)	27		24
25	Fund Raising, Advertising and Promotional	(4,067)	20		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	(15,295)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,200)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (33,200)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Seminars	\$ (3,413)	24	1
2	Travel & Sustenance	(9,773)	25	2
3	Depreciation	(2,109)	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	(15,295)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Childrens Home# 0011288

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	(6,643)	0	0	0	0	0	0	0	0	0	0	(6,643)	19
20	Fees, Subscriptions & Promotions	(5,302)	0	0	0	0	0	0	0	0	0	0	(5,302)	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	(3,413)	0	0	0	0	0	0	0	0	0	0	(3,413)	24
25	Other Admin. Staff Transportation	(9,773)	0	0	0	0	0	0	0	0	0	0	(9,773)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,078)	0	0	0	0	0	0	0	0	0	0	(4,078)	27
28	TOTAL General Administration	(29,209)	0	0	0	0	0	0	0	0	0	0	(29,209)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,209)	0	0	0	0	0	0	0	0	0	0	(29,209)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(2,109)	0	0	0	0	0	0	0	0	0	0	(2,109)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,882)	0	0	0	0	0	0	0	0	0	0	(1,882)	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	(3,991)	0	0	0	0	0	0	0	0	0	0	(3,991)	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)	(33,200)	0	0	0	0	0	0	0	0	0	0	(33,200)	45

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		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.

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	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								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Marklund Childrens Home# 0011288

Report Period Beginning:

07/01/2019Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	28,436,542	28,436,542	\$ 63	\$	3,148,224	\$ 7	1
2	2	Food	Direct Cost Budget	28,436,542	28,436,542	977		3,148,224	108	2
3	3	Housekeeping	Direct Cost Budget	28,436,542	28,436,542	4,584		3,148,224	507	3
4	5	Utilities	Direct Cost Budget	28,436,542	28,436,542	24,863		3,148,224	2,753	4
5	6	Maintenance	Direct Cost Budget	28,436,542	28,436,542	18,017		3,148,224	1,995	5
6	7	Disposal	Direct Cost Budget	28,436,542	28,436,542	1,292		3,148,224	143	6
7	13	BNATP	Direct Cost Budget	28,436,542	28,436,542	1,559		3,148,224	173	7
8	14	Transportation	Direct Cost Budget	28,436,542	28,436,542	0		3,148,224	0	8
9	19	Professional Services	Direct Cost Budget	28,436,542	28,436,542	98,000		3,148,224	10,850	9
10	20	Fees,Subscription	Direct Cost Budget	28,436,542	28,436,542	124,826		3,148,224	13,820	10
11	21	Clerical/Office	Direct Cost Budget	28,436,542	28,436,542	1,051,451	627,717	3,148,224	116,407	11
12	22	Benefits	Direct Cost Budget	28,436,542	28,436,542	169,328		3,148,224	18,746	12
13	24	Travel & Seminar	Direct Cost Budget	28,436,542	28,436,542	6,943		3,148,224	769	13
14	25	Staff Transportation	Direct Cost Budget	28,436,542	28,436,542	4,837		3,148,224	536	14
15	26	Insurance	Direct Cost Budget	28,436,542	28,436,542	32,682		3,148,224	3,618	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,539,422	\$ 627,717		\$ 170,432	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

[illegible]

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.**

FACILITY NAME Marklund Childrens Home COUNTY DuPage
FACILITY IDPH LICENSE NUMBER 0011288
CONTACT PERSON REGARDING THIS REPORT Kudus Badmus
TELEPHONE (630) 593-5487 FAX #: (630) 593-5501

Enter the tax index number and real estate tax assessed for 2019 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 2019.

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

A. Square Feet: 27,216

B. General Construction Type: Exterior BrickFrame Cement/Cinder BlockNumber of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

Marklund Community Day Services

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	Patient Care	206,930	1968	\$ 31,500	1
2					2
3	TOTALS	206,930		\$ 31,500	3

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	21		1968	1953	\$ 68,500	\$	33	\$	\$	68,500
5										
6										
7										
8										
	Improvement Type**									
9	BI extensive repair (parts/labor)			1998	2,675		5			2,675
10	BI Repair Roof, Gutters & Downspt			1999	8,800		5			8,800
11	BI Parts & Labor to install new			1999	2,580		15			2,580
12	BI MCH CONSTRUCTION-INTERIOR &			1999	3,899		10			3,899
13	BI EXTERIOR AWNINGS,ECU ENTRANCE			1999	3,994		15			3,994
14	BI WALL COVERINGS & PANELING			1999	7,309		5			7,309
15	BI MATERIAL & INSTALLATION - OAK			1999	8,160		5			8,160
16	BI ELEVATOR CONTROLLER & SECURITY			1999	11,010		15			11,010
17	BI WINDOWS & SHUTTERS FUNDED BY			1999	15,529		10			15,529
18	BI REGULAR & AUTOMATIC DOORS &			1999	18,259		10			18,259
19	BI PAINTING - RENOVATIONS & LOWER			1999	19,835		5			19,835
20	BI LOWER LEVEL CONST. PLUMBING			1999	21,177	529	20	529		21,177
21	BI DEMOLITION-REVOVAL WALLS,TILE			1999	26,641		10			26,641
22	BI ELECTRICAL WORK - LOWER LEVEL			1999	29,697		10			29,697
23	BI CABINETS (MATERIAL & INSTALLA)			1999	46,002		15			46,002
24	BI CONSTRUCTION-FLOORING &			1999	46,503		5			46,503
25	BI Survey,Architectural,Engineer,			1999	49,390		10			49,390
26	BI FIRE SPRINKLER SYSTEM			1999	72,843	2,914	25	2,914		59,731
27	BI CONTRUCTION-WALLS,CEILINGS			1999	101,713		10			101,713
28	BI INTERIOR DESIGN-TRIM,CORNER			1999	29,873		15			29,873
29	BI DOOR HARDWARE FOR NEW DOOR.			1999	197		10			197
30	BI FIRE ALARM SYSTEM FOR UPPER			1999	12,491	500	25	500		10,243
31	LI PARKING LOT CONCRETE/ASPHALT			1999	300		5			300
32	LI PARKING LOT CONCRETE/ASHAPLT			1999	32,199		5			32,199
33	BI FIRE DOORS REQUIRED BY IDPA			1999	564		10			564
34	BI LOWER LEVEL CLASSROOM RENOVATI			1999	1,346		5			1,346
35	BI FLOORING/CARPET INSTALLATION			1999	5,855		5			5,855
36	BI REPL WINDOW PER IDPA INSPECTIO			1999	538		5			538

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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 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	LI PARKING LOT - CONCRETE/ASPHALT	2000	300		5			300	40
41	BI SECURITY DOOR INCLUDING INSTA-	2000	2,427		5			2,427	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 COVR'D BY	2001	764		5			764	45
46	BI NEW WATER HEATER FUNDED BY	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	LI Concrete pad for garbage	2002	1,100		5			1,100	52
53	LI Concrete pad for O2 funded by	2002	3,204		5			3,204	53
54	LI Chiller concrete pad 649sq Ft	2002	4,900		5			4,900	54
55	BI Drive kit for auto sliding	2002	4,179		5			4,179	55
56	LI Fencing for for O2 and chiller	2002	2,927		5			2,927	56
57	BI Flotex Accent carpeting for	2002	1,690		5			1,690	57
58	LI Oxygen storage area Grading,	2002	3,440		5			3,440	58
59	BI Awning for O2 Concrete Pad	2002	2,694		5			2,694	59
60	BI Hot Water Heater	2004	4,529		5			4,529	60
61	LI Lndscpng-plant flowers, bushes	2005	4,055		5			4,055	61
62	BI MCH Renov: Shelvings	2005	1,118		10			1,118	62
63	BI MCH Renov: Electrical Work	2005	65,707		10			65,707	63
64	BI MCH Renov: Arch /Eng/Recon 43832	2005	2,571,858		10			2,571,858	64
65	BI MCH Renov: Piping & Plumbing	2005	114,194		10			114,194	65
66	LI MCH Renov: Light/Fenc/Lanscp	2005	38,190		10			38,190	66
67	BI Painting of 4 bedrooms	2005	3,875		5			3,875	67
68	BI Dugout Walls w/ doors & jams	2006	13,671		5			13,671	68
69	BI Roof Removal & Replacement	2006	62,340		10			62,340	69
70	TOTAL (lines 4 thru 69)		\$ 3,588,284	\$ 3,943		\$ 3,943	\$	\$ 3,572,924	70

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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	
1	Totals from Page 12A, Carried Forward		\$ 3,588,284	\$ 3,943		\$ 3,943		\$ 3,572,924	1
2	BI Fire Door Metal Edge Astragals	2006	1,730		5			1,730	2
3	BI HVAC Roof Repairs	2006	69,022		10			69,022	3
4	BI Electrical Work due to HVAC	2006	3,900		5			3,900	4
5	LI EXTERIOR SIGNAGE	2006	5,380		5			5,380	5
6	BI REMOVAL ASBESTOS TILE/MASTIC	2006	2,950		5			2,950	6
7	BI NEW CARPETING AND BASE ROOM 3	2006	4,420		5			4,420	7
8	BI Asbestos Consulting/Removal	2006	2,614		3			2,614	8
9	LI MCH Campus signs	2006	5,380		5			5,380	9
10	LI Tree removal/gravel/move shed	2007	1,150		5			1,150	10
11	LI SIDEWALK REPAIR	2007	3,300		5			3,300	11
12	BI ELECTRIC RECEPTACLES IN WIRE-	2007	3,645		5			3,645	12
13	BI BOILER REPAIR	2007	2,925		3			2,925	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	LI Peace Pole Garden: Peace Pole,	2009	2,837		5			2,837	18
19	BI Insulate Windows/Reinstall	2009	858		5			858	19
20	BI INSTALLATION OF WIREMOLD	2009	1,036		5			1,036	20
21	BI Tie doors into fire system	2009	1,695		5			1,695	21
22	LI Trees, Shrubs, Misc Plantings,	2009	10,240		5			10,240	22
23	BI Tuckpointing/Restoration to	2009	3,475		5			3,475	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	364	10	364		7,275	26
27	BI CONSTRUCTION: BLINDS,SHADES	2010	10,054	503	10	503		10,054	27
28	BI CONSTRUCTION: INSTALLATON OF	2010	1,990	100	10	100		1,990	28
29	BI AIR TESTING, MONITORING,	2010	3,420	171	10	171		3,420	29
30	BI Structural/Engineer Consults,	2010	72,963	3,555	20	3,555		39,194	30
31	BI Demo/ Bldg, Flooring, Masonry,	2010	75,010	3,654	20	3,654		40,294	31
32	BI Construct/Dryvall , painting,	2010	98,198	4,784	20	4,784		52,750	32
33	BI Const/Skylights, Doors, Frames	2010	111,060	5,411	20	5,411		59,659	33
34	TOTAL (lines 1 thru 33)		\$ 4,116,649	\$ 22,485		\$ 22,485		\$ 3,935,955	34

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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	
1	Totals from Page 12B, Carried Forward		\$ 4,116,649	\$ 22,485		\$ 22,485	\$	\$ 3,935,955	1
2	BI CONSTRUCTION: VINYL FLOORING,	2010	60,995	3,050	10	3,050		60,995	2
3	BI Const/Plumbing,Dental lines,	2010	143,610	6,996	20	6,996		77,144	3
4	BI Architect. Plans, Surveys,	2010	171,381	8,349	20	8,349		92,062	4
5	BI CONSTRUCT: MASONRY, CONCRETE	2010	238,587	11,623	20	11,623		128,164	5
6	BI CONSTRUCTION: Electrical Work	2010	282,582	13,767	20	13,767		151,797	6
7	BI CONSTRUCTION: GENERAL CONDIT,	2010	330,889	16,120	20	16,120		177,747	7
8	BI CONSTRUCTION: HEATING/VENTIL,	2010	335,130	16,327	20	16,327		180,025	8
9	BI Construction - Carpentry	2010	341,102	16,618	20	16,618		183,233	9
10	BI CONSTRUCTION: FIRE PROTECTION	2010	85,492	4,275	10	4,275		85,492	10
11	LI FENCES AND GATES	2010	2,310		5			2,310	11
12	LI -5 10'-12' SPRUCE TREES	2010	4,375		5			4,375	12
13	LI TRASH ENCLOSURE W/ORNAMENTAL	2010	6,295		5			6,295	13
14	LI EARTHWORK	2010	33,414	1,583	10	1,583		33,414	14
15	LI DRIVEWAY RECONSTRUCTION &	2010	88,608	4,197	10	4,197		88,608	15
16	LI SEALCOATING AND STRIPING OF	2010	2,451		2			2,451	16
17	BI CONNECT BACK-UP-PHONE,DOORS,	2010	4,800		5			4,800	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	LI Landscaping & installation of	2011	4,535		5			4,535	23
24	BI Exterior Handrail	2011	1,250		5			1,250	24
25	LI REFURBISHING OF EXTERIOR SIGNS	2012	6,100		5			6,100	25
26	LI ASPHALT REPAIRS TO DRIVEWAY	2012	825		5			825	26
27	BI Surge Suppression System	2012	2,583		5			2,583	27
28	LI 220 LF of 6"Barrier Curb	2012	7,902	790	10	790		5,927	28
29	LI 70 SF Unilock Stack Stone splt	2012	3,780		5			3,780	29
30	BI HM REPLACEMENT DOOR SET	2013	2,883		5			2,883	30
31	BI Rubber Flooring Replacement	2014	624		5			624	31
32	LI Concrete Walk to Connect to	2014	1,050	105	10	105		578	32
33	LI Sidewalk, Dumpster pad, ADA	2014	12,200	1,220	10	1,220		6,710	33
34	TOTAL (lines 1 thru 33)		\$ 6,304,721	\$ 127,505		\$ 127,505	\$	\$ 5,262,981	34

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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	
1	Totals from Page 12C, Carried Forward		\$ 6,304,721	\$ 127,505		\$ 127,505	\$	\$ 5,262,981	1
2	BI Installation of Bi-Fold Door	2014	1,925	193	5	193		1,925	2
3	LI Asphalt Driveway Renovation	2014	60,950	6,095	10	6,095		33,523	3
4	LI Sidewalk Railings	2014	1,450	145	10	145		798	4
5	LI REFURBISH/REVISE OUTDOOR SIGN	2015	2,467	247	5	247		2,467	5
6	BI Ladder for Elevator Pit	2015	973	97	10	97		438	6
7	LI Repair Existing Concrete	2015	2,178	109	20	109		490	7
8	BI Repainting Roof MPC	2015	11,925	1,193	10	1,193		5,366	8
9	BI Rem & Repl Hydrant, Ins Sewer	2015	5,344	1,069	5	1,069		4,810	9
10	BI Flooring Replacement (Pod1)	2016	8,850	885	10	885		3,983	10
11	BI Data Line Install 10 lines 5dp	2016	78	8	10	8		27	11
12	BI Electric Outlet Orient Room &	2016	66	3	20	3		12	12
13	BI CARPETING-NEW ORIENTATION ROOM	2016	288	58	5	58		201	13
14	BI Hand Rail Replacement Exterior	2017	4,250	425	10	425		1,488	14
15	BI Relocate Outlets Higher Wall	2017	3,900	390	10	390		1,365	15
16	LI Outdoor New Logo Sign	2017	2,900	242	12	242		604	16
17	BI Wall Protection Areas	2017	3,300	660	5	660		1,650	17
18	BI Fiber & Cable Install Elevator	2017	791	158	5	158		396	18
19	BI Firestopping Installation	2017	767	77	10	77		192	19
20	BI Outside Lighting Update to LED	2018	2,875	288	10	288		719	20
21	BI Paint Nrt Ent Ped#1 Ceil Bk Rm	2018	3,795	759	5	759		1,898	21
22	BI Epoxy Floor Janitor's Closet	2018	1,500	300	5	300		750	22
23	BI Chimney Repair Stain Steel W/	2018	4,850	485	10	485		728	23
24	BI Door Replacement Splt W/MN	2019	1,210	121	10	121		181	24
25	BI HVAC Repair Spd Cont & Sgnl	2019	539	108	5	108		162	25
26	BI Circulating Pump Replacement	2019	3,600	360	10	360		540	26
27	BI Canopy Replacement Splt MDS	2019	2,102	420	5	420		631	27
28	LI Concrete Pad Whsperglide Swing	2019	2,750	138	10	138		138	28
29	LI Stripe Crackseal sealcoat	2019	1,685	421	2	421		421	29
30	BI Wood Fire Rated Door & Install	2019	1,730	86	10	86		86	30
31	BI Filtration Sys Valves Piping	2020	7,271	364	10	364		364	31
32	BI Circulating Pump - Boiler	2020	2,537	254	5	254		254	32
33	BI Gas Heater in Mechanical Room	2020	3,440	344	5	344		344	33
34	TOTAL (lines 1 thru 33)		\$ 6,457,007	\$ 144,007		\$ 144,007	\$	\$ 5,329,932	34

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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 12D, Carried Forward		\$ 6,457,007	\$ 144,007		\$ 144,007	\$	\$ 5,329,932	1
2	BI Gutter Installation	2020	1,788	89	10	89		89	2
3	BI Panic Button System Splt Homes	2020	2,178	218	5	218		218	3
4	BI HVAC Repair Vibration Elimintr	2020	3,471	347	5	347		347	4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
13									13
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,464,444	\$ 144,661		\$ 144,661	\$	\$ 5,330,586	34

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

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	\$186,955	\$28,363	\$28,363	\$	5	\$83,640	71
72	Current Year Purchases	41,448	5,219	5,219		5	5,219	72
73	Fully Depreciated Assets	575,468	6,575	6,575		5	575,468	73
74								74
75	TOTALS	\$803,871	\$40,157	\$40,157	\$		\$664,327	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	2009 Ford Mobility Van	2009	\$34,475	\$	\$	\$	5	\$34,475	76
77	Patient Trasnport	2020 Ford Transit Connect	2020	26,976	2,698	2,698		5	2,698	77
78	Patient Transport	2017 El Dorado Bus	2018	62,608	12,522	12,522		5	31,304	78
79										79
80	TOTALS			\$124,059	\$15,220	\$15,220	\$		\$68,477	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)	\$7,423,874	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$200,038	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$200,038	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)	\$6,063,390	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.

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.

		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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$6,922Description: 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.

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

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.

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):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

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	\$ 6,348,539	\$ 6,348,539	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 319,818)	4,633,727	4,633,727	3
4	Supply Inventory (priced at)	91,805	91,805	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	330,340	330,340	7
8	Accounts Receivable (owners or related parties)	709,603	709,603	8
9	Other(specify): Client Related Accounts	477,230	477,230	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,591,244	\$ 12,591,244	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,282,287	1,282,287	11
12	Long-Term Investments			12
13	Land	7,918,001	7,918,001	13
14	Buildings, at Historical Cost	29,694,293	29,694,293	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,300,602	6,300,602	16
17	Accumulated Depreciation (book methods)	(26,678,871)	(26,678,871)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	10,888,230	10,888,230	21
22	Other Long-Term Assets (specify) PPP loan & other	8,613,855	8,613,855	22
23	Other(specify): construction in progress	9,921,644	9,921,644	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,940,041	\$ 47,940,041	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 60,531,285	\$ 60,531,285	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 294,114	\$ 294,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	272,816	272,816	29
30	Accrued Salaries Payable	856,741	856,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	63,115	63,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,263,189	1,263,189	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Construction payables	1,047,238	1,047,238	36
37	Misc. Other	2,058,701	2,058,701	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,855,913	\$ 5,855,913	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,274,768	6,274,768	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Paycheck Protection Program loan	3,879,650	3,879,650	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,154,418	\$ 10,154,418	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 16,010,331	\$ 16,010,331	46
47	TOTAL EQUITY (page 18, line 24)	\$ 44,520,954	\$ 44,520,954	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 60,531,285	\$ 60,531,285	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 39,797,188	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 39,797,188	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(120,873)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	872,412	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	3,925,889	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 4,677,428	17
	B. Transfers (Itemize):		
18	transfers out in to operations-expenses	46,338	18
19	transfers out in to operations-capial	2,872,497	19
20	transfers out in to operations-capial	(2,872,497)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 46,338	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 44,520,954	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

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	\$ 3,294,717	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,294,717	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		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,301	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)	\$ 4,301	23
	D. Non-Operating Revenue		
24	Contributions	62,668	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,668	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,361,686	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	365,751	31
32	Health Care	1,901,892	32
33	General Administration	849,367	33
	B. Capital Expense		
34	Ownership	204,029	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	161,520	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,482,559	40
41	Income before Income Taxes (line 30 minus line 40)**	(120,873)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (120,873)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,277,527	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA	17,190	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,294,717	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	1,778	1,872	\$ 86,018	\$ 45.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,192	21,255	686,115	32.28	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	32,227	33,923	653,024	19.25	5
6	CNA Trainees					6
7	Licensed Therapist	1,976	2,080	87,672	42.15	7
8	Rehab/Therapy Aides	2,075	2,184	39,858	18.25	8
9	Activity Director	593	624	12,854	20.60	9
10	Activity Assistants	1,056	1,112	21,517	19.35	10
11	Social Service Workers	198	208	6,001	28.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,309	1,378	32,806	23.81	17
18	Housekeepers	5,922	6,234	90,399	14.50	18
19	Laundry	2,600	2,737	45,131	16.49	19
20	Administrator	790	832	50,319	60.48	20
21	Assistant Administrator					21
22	Other Administrative	99	104	13,584	130.62	22
23	Office Manager					23
24	Clerical	3,359	3,536	84,829	23.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	38,938	18.72	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	247	260	4,462	17.16	31
32	Other Health Care(specify)	198	208	2,808	13.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,595	80,627	\$ 1,956,335 *	\$ 24.26	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	77	\$ 3,838	1	35
36	Medical Director	monthly	25,484	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	2,527	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	78	5,460	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	33	2,765	15	46
47	Vision	visit	405	15	47
48	Dental	vist	450	15	48
49	TOTAL (lines 35 - 48)	187	\$ 40,930		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,097	\$ 51,510	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	39	985	10	52
53	TOTAL (lines 50 - 52)	1,137	\$ 52,495		53

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 , \$1,251
- (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. \$ 15,822 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. \$ 161,520
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 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? yes
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) 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.

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Canon	IR4535III	1
Copier	Canon	IRC5550III	1
Copier	Canon	IRC3530III	1

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