

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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.

<p>I. IDPH Facility ID Number: <u>0011288</u></p> <p>Facility Name: <u>Marklund Children's Home</u></p> <p>Address: <u>164 S. Prairie Ave.</u> <u>Bloomington</u> <u>60108</u> Number City Zip Code</p> <p>County: <u>DuPage</u></p> <p>Telephone Number: <u>(630) 593-5479</u> Fax # <u>(630) 593-5481</u></p> <p>IDPA ID Number: <u>36-2652532</u></p> <p>Date of Initial License for Current Owners: <u>10/01/68</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) 3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Lisa Lipira</u> Telephone Number: <u>(630) 593-5479</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/03</u> to <u>06/30/04</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Lisa Lipira</u></td> </tr> <tr> <td></td> <td>(Title) <u>CFO/Executive Director</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Lisa Lipira</u>		(Title) <u>CFO/Executive Director</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
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Paid Preparer	(Signed) _____ (Date) _____																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) (____) _____ Fax # (____) _____																																		

Facility Name & ID Number Marklund Children's Home

0011288 Report Period Beginning: 07/01/03 Ending: 06/30/04

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	90	Skilled Pediatric (SNF/PED)	30	20,307	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	30	20,307	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			
		2 Public Aid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED	14,151	535		14,686
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	14,151	535		14,686

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.32%

D. How many bed-hold days during this year were paid by Public Aid? 469 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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: 06/30/04 Fiscal Year: 06/30/04

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/03 Ending: 06/30/04**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	98,726	6,844	10,559	116,129		116,129		116,129		1
2	Food Purchase		92,461		92,461		92,461		92,461		2
3	Housekeeping	66,830	14,141		80,971		80,971		80,971		3
4	Laundry	19,427	14,219		33,646		33,646		33,646		4
5	Heat and Other Utilities			95,037	95,037		95,037		95,037		5
6	Maintenance	20,800	35,005	41,249	97,054		97,054		97,054		6
7	Other (specify):* Disposal			18,203	18,203		18,203		18,203		7
8	TOTAL General Services	205,783	162,670	165,048	533,501		533,501		533,501		8
	B. Health Care and Programs										
9	Medical Director			30,879	30,879		30,879		30,879		9
10	Nursing and Medical Records	1,152,902	144,339	434,810	1,732,051	(415,309)	1,316,742		1,316,742		10
10a	Therapy	56,160	401	11,350	67,911		67,911		67,911		10a
11	Activities	26,208	12,809	775	39,792		39,792		39,792		11
12	Social Services	16,058			16,058		16,058		16,058		12
13	Nurse Aide Training		87		87	55,578	55,665		55,665		13
14	Program Transportation	9,651		14,604	24,255		24,255		24,255		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,260,979	157,636	492,418	1,911,033	(359,731)	1,551,302		1,551,302		16
	C. General Administration										
17	Administrative	50,003			50,003		50,003		50,003		17
18	Directors Fees										18
19	Professional Services			18,664	18,664		18,664	(11,929)	6,735		19
20	Dues, Fees, Subscriptions & Promotions			47,180	47,180		47,180	(18,840)	28,340		20
21	Clerical & General Office Expenses	139,258	44,962	38,722	222,942	(3,794)	219,148		219,148		21
22	Employee Benefits & Payroll Taxes			319,207	319,207		319,207		319,207		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,762	4,762		4,762		4,762		24
25	Other Admin. Staff Transportation			12,089	12,089		12,089		12,089		25
26	Insurance-Prop.Liab.Malpractice			70,942	70,942		70,942		70,942		26
27	Other (specify):* Fundraising/Promo			22,470	22,470		22,470	(22,470)			27
28	TOTAL General Administration	189,261	44,962	534,036	768,259	(3,794)	764,465	(53,239)	711,226		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,656,023	365,268	1,191,502	3,212,793	(363,525)	2,849,268	(53,239)	2,796,029		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Marklund Children's Home

#0011288

Report Period Beginning:

07/01/03

Ending:

06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			220,895	220,895		220,895	(39,581)	181,314			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,932	4,932		4,932	(4,932)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			51,938	51,938		51,938	(51,938)				34
35	Rent-Equipment & Vehicles					3,794	3,794		3,794			35
36	Other (specify):*											36
37	TOTAL Ownership			277,765	277,765	3,794	281,559	(96,451)	185,108			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					359,731	359,731		359,731			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			360,616	360,616		360,616		360,616			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			360,616	360,616	359,731	720,347		720,347			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,656,023	365,268	1,829,883	3,851,174		3,851,174	(149,690)	3,701,484			45

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

Facility Name & ID Number **Marklund Children's Home**

0011288

Report Period Beginning: **07/01/03**

Ending: **06/30/04**

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	4,932	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	18,840	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	11,929	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	22,470	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Non-Care related assets	39,581	30		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 97,752		\$	30

OHF 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	51,938	34	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 51,938		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 149,690		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Marklund Children's Home

ID# 0011288

Report Period Beginning: 07/01/03

Ending: 06/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Fundraising/Promotional	\$ 51,938	34	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
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	Total	51,938		48
49				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home# 0011288

Report Period Beginning:

07/01/03

Ending:

06/30/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	11,929	0	0	0	0	0	0	0	0	0	0	11,929	19
20	Fees, Subscriptions & Promotions	18,840	0	0	0	0	0	0	0	0	0	0	18,840	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	22,470	0	0	0	0	0	0	0	0	0	0	22,470	27
28	TOTAL General Administration	53,239	0	0	0	0	0	0	0	0	0	0	53,239	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	53,239	0	0	0	0	0	0	0	0	0	0	53,239	29

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning: 07/01/03

Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/03 Ending: 06/30/04

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 Children's Home

0011288 Report Period Beginning: 07/01/03

Ending: 06/30/04

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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	12,876,286	12,876,286	\$ 457	\$	2,477,357	\$ 88	1
2	2	Food	12,876,286	12,876,286	2,134		2,477,357	411	2
3	3	Housekeeping	12,876,286	12,876,286	12,900		2,477,357	2,482	3
4	5	Utilities	12,876,286	12,876,286	61,629		2,477,357	11,857	4
5	6	Maintenance	12,876,286	12,876,286	22,512		2,477,357	4,331	5
6	7	Disposal	12,876,286	12,876,286	30,499		2,477,357	5,868	6
7	13	BNATP	12,876,286	12,876,286	450		2,477,357	87	7
8	14	Transportation	12,876,286	12,876,286	233		2,477,357	45	8
9	19	Professional Services	12,876,286	12,876,286	35,004		2,477,357	6,735	9
10	20	Fees, Subscription	12,876,286	12,876,286	129,044		2,477,357	24,828	10
11	21	Clerical/Office	12,876,286	12,876,286	656,826	488,661	2,477,357	140,162	11
12	22	Benefits	12,876,286	12,876,286	94,192		2,477,357	20,781	12
13	24	Travel & Seminars	12,876,286	12,876,286	13,428		2,477,357	2,584	13
14	25	Staff Transportation	12,876,286	12,876,286	22,028		2,477,357	4,238	14
15	26	Insurance	12,876,286	12,876,286	14,004		2,477,357	2,694	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,095,340	\$ 488,661		\$ 227,191	25

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/03 Ending: 06/30/04

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2003 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	N/A	8
	2000		9
	2001		10
	2002		11
	2003		12
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2003 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 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 Lisa Lipira

TELEPHONE (630) 593-5500 FAX #: (630) 593-5481

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 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 2003.

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

B. Real Estate Tax Cost Allocation:

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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

Facility Name & ID Number Marklund Children's Home

0011288 Report Period Beginning:

07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2C. 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 ground:
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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	Patient Care	206,930	1968	\$ 31,500	1
2					2
3	TOTALS	206,930		\$ 31,500	3

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	32	1968	1953	\$ 68,500	\$	33	\$	\$	\$ 68,500	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Pavillon land impr		1989	6,485	327	20	327		5,029	9
10	Landscaping land impr		1990	1,080		10			1,080	10
11	Asphalt Paving Land impr		1991	7,112		5			7,112	11
12	Asphalt Seal & Strip Parking Lot land impr		1994	14,893		5			14,893	12
13	Asphalt Land impr		1996	800		5			800	13
14	Seal & Repair Driveway Land impr		1998	600	60	5	60		600	14
15	Parking Lot Concrete Asphalt land impr		1999	300	60	5	60		270	15
16	Parking Lot Concrete Asphalt land impr		1999	32,199	6,440	5	6,440		28,979	16
17	Removal of ramp & installation of new land impr		1999	2,100	420	5	420		1,890	17
18	Parking Lot Concrete Asphalt land impr		2000	300	60	5	60		270	18
19	Resurface Playground land impr		2000	7,750	1,550	5	1,550		5,425	19
20	Sealcoat & Striping of Parking lot land impr		2000	3,187	637	5	637		2,231	20
21	Safety Surfacing of Playground		2000	6,094	1,219	5	1,219		4,266	21
22	Landscaping of Playground land impr		2000	3,325	665	5	665		2,328	22
23	Improvements prior to 1996 fully depreciated			208,807		v			208,807	23
24	Building Construction Pod II		1973	615,786	17,009	40	17,009		488,201	24
25	Oxygen Work		1974	74,064	2,047	40	2,047		56,657	25
26	Oxygen Work		1975	5,000	135	40	135		3,716	26
27	Oxygen Work		1976	7,535	190	40	190		5,416	27
28	New Roof		1986	81,000	4,050	20	4,050		74,925	28
29	Lobby Addition		1984	108,605	5,030	25	5,030		90,999	29
30	Parents Room		1987	42,000	2,100	20	2,100		34,650	30
31	POD general renovations floors/walls		1992	22,173		10			22,173	31
32	Fire Alarm		1993	850		10			850	32
33	Oxygen System		1993	13,429		10			13,429	33
34	Carpeting		1995	2,984	298	10	298		2,835	34
35	Water Heaters		1995	8,916	892	10	892		8,471	35
36	Vinyl Tile Flooring - Dental Office		1995	644	64	10	64		547	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Window shades dining room	2000	\$ 605	\$ 121	5	\$ 121	\$	\$ 545		37
38	Lobby walls	2000	57	12	5	12		52		38
39	Awnings rear entrance	2000	2,023	405	5	405		1,821		39
40	lower level classroom renovations	2000	183	37	5	37		165		40
41	awning for O2 protection	2000	3,477	695	5	695		3,129		41
42	Lobby walls	2000	4,997	999	5	999		4,497		42
43	HVAC-dining room	2000	610	122	5	122		549		43
44	Dining room walls & wall coverings	2000	2,060	412	5	412		1,854		44
45	HVAC coil dining room	2000	1,590	318	5	318		1,431		45
46	fire doors lower level	2000	564	57	5	57		254		46
47	carpet flooring lower level	1999	5,855	1,171	5	1,171		5,270		47
48	lower level classroom renovation	1999	1,346	269	5	269		1,212		48
49	replacement windows	1999	538	108	5	108		484		49
50	Construction, engineering, architect, inspection	1999	49,390	4,939	10	4,939		22,226		50
51	fire sprinkler system	1999	72,843	2,914	25	2,914		13,112		51
52	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		8,962		52
53	Demolition old lower level	1999	26,641	2,664	10	2,664		11,988		53
54	Chair rails	1999	8,160	1,632	5	1,632		7,344		54
55	Wall Carpet	1998	4,887	489	5	489		4,887		55
56	Painting lower level	1999	19,835	3,967	5	3,967		17,852		56
57	lower level construction walls	1999	101,713	10,171	10	10,171		45,771		57
58	cabinets	1999	46,002	3,067	15	3,067		13,801		58
59	Reg. & auto doors	1999	18,259	1,825	10	1,825		8,216		59
60	Equip relocation	1999	2,495	499	5	499		2,246		60
61	Electrical work lower level	1999	29,697	2,970	10	2,970		13,364		61
62	windows/shutters	1999	15,529	1,553	10	1,553		7,765		62
63	Floor/carpeting	1999	46,503	9,301	5	9,301		41,853		63
64	Signage Interior/Exterior	1999	3,899	390	10	390		1,755		64
65	Plumbing lower level	1999	21,177	1,059	20	1,059		4,765		65
66	ECU Awnings	1999	3,994	266	15	266		1,198		66
67	Paneling	1999	7,309	1,462	5	1,462		6,578		67
68	Security System,Elevator	1999	11,010	734	15	734		3,303		68
69	New door hardware	1999	197	20	10	20		89		69
70	TOTAL (lines 4 thru 69)		\$ 1,889,836	\$ 99,892		\$ 99,892	\$	\$ 1,413,681		70

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 1,889,836	\$ 99,892		\$ 99,892		\$ 1,413,681		1
2	Fire alarm system upper level	1999 12,491	499	25	499		2,248		2
3	Water Heater	2001 767	153	5	153		537		3
4	Air Curtain	2001 764	153	5	153		535		4
5	Replacement Parts - Boiler	2001 5,290	1,058	5	1,058		3,703		5
6	Compressor Pump	2001 1,599	320	5	320		1,120		6
7	Security Door	2001 2,427	486	5	486		1,699		7
8	New Flooring	2000 2,955	591	5	591		2,659		8
9	Roof Repair	1999 8,800	880	5	880		8,800		9
10	New compressor	1999 2,580	172	15	172		946		10
11	Awnings	1999 2,520	252	5	252		2,520		11
12	Boiler	1998 2,675	267	5	267		2,675		12
13	Plexiglass-reception area	2002 3,100	620	5	620		1,550		13
14	Stairwell Door replacements	2001 1,165	233	5	233		583		14
15	New Radiator for generator	2001 3,002	600	5	600		1,501		15
16	Sliding door repair	2002 4,179	836	5	836		1,254		16
17	Carpeting	2002 1,690	338	5	338		507		17
18	Awning	2002 2,694	540	5	540		809		18
19	Concrete Pads for Oxygen, Chiller, and Garbage	2002 15,571	3,114	5	3,114		4,671		19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,964,105	\$ 111,005		\$ 111,005		\$ 1,451,996		34

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

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 427,503	\$ 46,530	\$ 46,530	\$		\$ 379,769	71
72	Current Year Purchases	33,325	3,139	3,139			3,139	72
73	Fully Depreciated Assets	628,641					628,641	73
74								74
75	TOTALS	\$ 1,089,469	\$ 49,669	\$ 49,669	\$		\$ 1,011,549	75

D. Vehicle Depreciation (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	2000 International Bus	2000	\$ 62,500	\$ 12,500	\$ 12,500	\$		\$ 56,250	76
77	Maintenance use	Isuzu Truck	2004	34,940	4,367	4,367			4,367	77
78	General/Laundry use	Ford E250	2000	18,867	3,773	3,773			13,207	78
79										79
80	TOTALS			\$ 116,307	\$ 20,641	\$ 20,641	\$		\$ 73,824	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)	\$ 3,201,380 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 181,314 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 181,314 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)	\$ 1,525,821 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: _____

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

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.	<u> </u> /2005	\$ <u> </u>
13.	<u> </u> /2006	\$ <u> </u>
14.	<u> </u> /2007	\$ <u> </u>

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: \$ 3,794 Description: Office Equipment/Machinery
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>87</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>44</u></p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	22	65		87
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	13,895	41,683		55,578
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$ 55,665
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	12

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	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 prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program	Line 39, Col. 8	8760	264,990				94,741		8,760	359,731			12
13	Other (specify):													13
14	TOTAL			\$ 264,990		\$		\$ 94,741		8,760	\$ 359,731			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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning: 07/01/03

Ending:

06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/04

(last day of reporting year)

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	\$ 2,537,681	\$ 2,537,681	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 101,502)	1,683,233	1,683,233	3
4	Supply Inventory (priced at Cost)	53,700	53,700	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	128,915	128,915	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Client Related Accounts	582,242	582,242	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,985,771	\$ 4,985,771	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,158,615	6,158,615	13
14	Buildings, at Historical Cost	17,654,573	17,654,573	14
15	Leasehold Improvements, at Historical Cost	4,547	4,547	15
16	Equipment, at Historical Cost	4,383,065	4,383,065	16
17	Accumulated Depreciation (book methods)	(8,244,217)	(8,244,217)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,054,166	7,054,166	21
22	Other Long-Term Assets (specify):	2,138,042	2,138,042	22
23	Other(specify): Construction in Progress	1,678,117	1,678,117	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 30,826,908	\$ 30,826,908	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 35,812,679	\$ 35,812,679	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 650,291	\$ 650,291	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,131	254,131	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,330	20,330	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	Other-compensation&related payables	1,093,628	1,093,628	36
37	Misc. Other	2,465,598	2,465,598	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,483,978	\$ 4,483,978	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)	\$ 4,483,978	\$ 4,483,978	46
47	TOTAL EQUITY(page 18, line 24)	\$ 31,328,701	\$ 31,328,701	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,812,679	\$ 35,812,679	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,365,586	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,365,586	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	405,136	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,733,960	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 Cosolidated Inc/(Loss)	(1,647,933)	15
16	Other (describe) Change in Unrealized Gains/(Losses)	525,233	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,016,396	17
B. Transfers (Itemize):			
18	Transfer out of Restricted Funds into Operations-Expenses	(53,281)	18
19	Transfer out of Restricted Funds into Operations-Capital	(521,349)	19
20	Transfer into Operations from Restricted Funds - Capital	521,349	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (53,281)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 31,328,701	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning: 07/01/03

Ending:

06/30/04

VII. 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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,378,412	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,378,412	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	5,147	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,147	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,732	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	103	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	11,700	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)	\$ 13,535	23
D. Non-Operating Revenue			
24	Contributions	709,526	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 709,526	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)	\$ 4,106,620	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	533,501	31
32	Health Care	1,551,302	32
33	General Administration	711,226	33
B. Capital Expense			
34	Ownership	185,108	34
C. Ancillary Expense			
35	Special Cost Centers	359,731	35
36	Provider Participation Fee	360,616	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,701,484	40
41	Income before Income Taxes (line 30 minus line 40)**	405,136	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 405,136	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning: 07/01/03

Ending:

06/30/04

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	\$ 57,013	\$ 27.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,377	19,344	527,898	27.29	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	38,927	40,976	501,136	12.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,581	1,664	51,584	30.73	7
8	Rehab/Therapy Aides	395	416	4,576	11.00	8
9	Activity Director					9
10	Activity Assistants	1,976	2,080	26,208	12.60	10
11	Social Service Workers	988	1,040	16,058	15.44	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,080	37,440	18.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,952	4,160	53,997	12.98	15
16	Dishwashers	534	562	7,290	12.97	16
17	Maintenance Workers	988	1,040	20,800	20.00	17
18	Housekeepers	6,797	7,155	66,830	9.34	18
19	Laundry	1,976	2,080	19,427	9.34	19
20	Administrator	1,976	2,080	50,003	24.04	20
21	Assistant Administrator					21
22	Other Administrative	4,228	4,451	107,808	24.22	22
23	Office Manager					23
24	Clerical	3,319	3,494	31,450	9.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,557	3,744	56,871	15.19	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	790	832	9,984	12.00	31
32	Other Health Care Transportation	790	832	9,651	11.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,105	100,110	\$ 1,656,024 *	\$ 16.54	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	199	\$ 9,846	1	35
36	Medical Director	Monthly	30,879	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	35	1,058	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	162	4,865	10	42
43	Speech Therapy Consultant	184	10,292	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	580	\$ 56,940		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,822	\$ 279,464	10	50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,374	150,481	10	52
53	TOTAL (lines 50 - 52)	11,196	\$ 429,945		53

Facility Name & ID Number Marklund Children's Home# 0011288Report Period Beginning: 07/01/03Ending: 06/30/04**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 \$3,266
- (3) Did the nursing home make political contributions or payments to a political 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? _____ 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. \$ 31,702 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 of Public Aid during this cost report period. \$ 360,616
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (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? Yes (NDSEC Rent) 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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 15%
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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>Location</u>	<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
MCH	Copier	Minolta	DI 550	1
	Fax	Minolta	2600	1
	Fax	Minolta	1600	1
	Copier	Lanier	6720AG	1

Long term care cost report
Fiscal Year 2004

Marklund Childrens Home

Reclassifications:

Line 10	BNATP Wages	\$55,578.00
	Exceptional Care Wages	\$264,990.00
	Exceptional Care Supplies	<u>\$94,741.00</u>
	Total Line 10	\$415,309.00
Line 13	Training Supplies	\$55,578.00
Line 21	Office equipment rental	\$3,794.00
Line 35	Office equipment rental	\$3,794.00
Line 39	Exceptional Care Program	\$359,731.00