

Facility Name & ID Number Marklund Children's Home

0011288 Report Period Beginning: 07/01/08 Ending: 06/30/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	30	Skilled Pediatric (SNF/PED)	30	10,950	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,950	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	7,129	356	0	7,485	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,129	356		7,485	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.36%

D. How many bed-hold days during this year were paid by the Department? 162 (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: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		1,049	4,752	5,801		5,801		5,801		1
2	Food Purchase		53,740		53,740		53,740		53,740		2
3	Housekeeping	48,256	7,660	17	55,933		55,933		55,933		3
4	Laundry	20,268	6,131		26,399		26,399		26,399		4
5	Heat and Other Utilities			59,076	59,076		59,076		59,076		5
6	Maintenance	23,995	8,708	41,589	74,292		74,292		74,292		6
7	Other (specify):* Disposal Service			13,075	13,075		13,075		13,075		7
8	TOTAL General Services	92,519	77,288	118,509	288,316		288,316		288,316		8
	B. Health Care and Programs										
9	Medical Director			29,732	29,732		29,732		29,732		9
10	Nursing and Medical Records	975,142	144,196	127,721	1,247,059	(410,603)	836,456		836,456		10
10a	Therapy	49,623	755	3,044	53,422		53,422		53,422		10a
11	Activities	20,723	11,981		32,704		32,704		32,704		11
12	Social Services	4,992			4,992		4,992		4,992		12
13	CNA Training		20		20		20		20		13
14	Program Transportation			27,689	27,689		27,689		27,689		14
15	Other (specify):* Vision,Dental,Pharmacy,Psychologist Consultants			2,527	2,527		2,527		2,527		15
16	TOTAL Health Care and Programs	1,050,480	156,952	190,713	1,398,145	(410,603)	987,542		987,542		16
	C. General Administration										
17	Administrative	77,210			77,210		77,210		77,210		17
18	Directors Fees										18
19	Professional Services			11,420	11,420		11,420	(5,172)	6,248		19
20	Dues, Fees, Subscriptions & Promotions			28,935	28,935		28,935	(8,039)	20,896		20
21	Clerical & General Office Expenses	92,075	47,611	36,041	175,727	(7,661)	168,066		168,066		21
22	Employee Benefits & Payroll Taxes			239,237	239,237		239,237		239,237		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,283	5,283		5,283		5,283		24
25	Other Admin. Staff Transportation			6,213	6,213		6,213		6,213		25
26	Insurance-Prop.Liab.Malpractice			69,503	69,503		69,503		69,503		26
27	Other (specify):* fund-raising promo			2,578	2,578		2,578	(2,578)			27
28	TOTAL General Administration	169,285	47,611	399,210	616,106	(7,661)	608,445	(15,789)	592,656		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,312,284	281,851	708,432	2,302,567	(418,264)	1,884,303	(15,789)	1,868,514		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:

07/01/08

Ending:

06/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			443,985	443,985		443,985	(22,522)	421,463			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,438	8,438		8,438	(8,438)				32
33	Real Estate Taxes			154	154		154	(154)	(0)			33
34	Rent-Facility & Grounds			19,964	19,964		19,964	(19,964)	0			34
35	Rent-Equipment & Vehicles					7,661	7,661		7,661			35
36	Other (specify):*											36
37	TOTAL Ownership			472,541	472,541	7,661	480,202	(51,078)	429,124			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					410,603	410,603		410,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,541	131,541		131,541		131,541			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			131,541	131,541	410,603	542,144		542,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,312,284	281,851	1,312,514	2,906,649		2,906,649	(66,867)	2,839,782			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,039)	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	(5,172)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,502)	27		24
25	Fund Raising, Advertising and Promotional	(76)	27		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	(42,640)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,867)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (66,867)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Marklund Children's Home

ID# 0011288

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Depreciation	\$ (22,522)	30	1
2	Real Estate Taxes	(154)	33	2
3	Rent	(19,964)	34	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	(42,640)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	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	(5,172)	0	0	0	0	0	0	0	0	0	0	(5,172)	19
20	Fees, Subscriptions & Promotions	(8,039)	0	0	0	0	0	0	0	0	0	0	(8,039)	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):*	(2,578)	0	0	0	0	0	0	0	0	0	0	(2,578)	27
28	TOTAL General Administration	(15,789)	0	(15,789)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,789)	0	(15,789)	29									

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/08 Ending:

06/30/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(22,522)	0	0	0	0	0	0	0	0	0	0	(22,522)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,438)	0	0	0	0	0	0	0	0	0	0	(8,438)	32
33	Real Estate Taxes	(154)	0	0	0	0	0	0	0	0	0	0	(154)	33
34	Rent-Facility & Grounds	(19,964)	0	0	0	0	0	0	0	0	0	0	(19,964)	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	(51,078)	0	0	0	0	0	0	0	0	0	0	(51,078)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(66,867)	0	0	0	0	0	0	0	0	0	0	(66,867)	45

Facility Name & ID Number

Marklund Children's Home

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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.

VII. RELATED PARTIES (continued)

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)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

Marklund Children's Home

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0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

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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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Cost Budget	13,061,882	13061882	\$ 86	\$ 2,702,208	\$ 18	1
2	2	Food	Direct Cost Budget	13,061,882	13061882	1,130	2,702,208	234	2
3	3	Housekeeping	Direct Cost Budget	13,061,882	13061882	5,792	2,702,208	1,198	3
4	5	Utilities	Direct Cost Budget	13,061,882	13061882	71,551	2,702,208	14,802	4
5	6	Maintenance	Direct Cost Budget	13,061,882	13061882	31,030	2,702,208	6,419	5
6	7	Disposal	Direct Cost Budget	13,061,882	13061882	11,171	2,702,208	2,311	6
7	13	BNATP	Direct Cost Budget	13,061,882	13061882	98	2,702,208	20	7
8	14	Transportation	Direct Cost Budget	13,061,882	13061882	7,122	2,702,208	1,473	8
9	19	Professional Services	Direct Cost Budget	13,061,882	13061882	30,200	2,702,208	6,248	9
10	20	Fees,Subscription	Direct Cost Budget	13,061,882	13061882	94,547	2,702,208	19,560	10
11	21	Clerical/Office	Direct Cost Budget	13,061,882	13061882	208,536	2,702,208	43,141	11
12	22	Benefits	Direct Cost Budget	13,061,882	13061882	98,196	2,702,208	20,315	12
13	24	Travel & Seminar	Direct Cost Budget	13,061,882	13061882	15,808	2,702,208	3,270	13
14	25	Staff Transportation	Direct Cost Budget	13,061,882	13061882	9,860	2,702,208	2,040	14
15	26	Insurance	Direct Cost Budget	13,061,882	13061882	21,007	2,702,208	4,346	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 606,134	\$ 2,702,208	\$ 125,395	25

Facility Name & ID Number

Marklund Children's Home

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

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

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

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

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Patient Care</u>	<u>206,930</u>	<u>1968</u>	<u>\$ 31,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	206,930		\$ 31,500	3

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	30		1968	1953	\$ 68,500	\$	33	\$	\$	\$ 68,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Pavillon land impr		1989	6,485	154	20	154		6,485	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		5			600	14
15		Parking Lot Concrete Asphalt land impr		1999	300		5			300	15
16		Parking Lot Concrete Asphalt land impr		1999	32,199		5			32,199	16
17		Removal of ramp & installation of new land impr		1999	2,100		5			2,100	17
18		Parking Lot Concrete Asphalt land impr		2000	300		5			300	18
19		Resurface Playground land impr		2000	7,750		5			7,750	19
20		Sealcoat & Striping of Parking lot land impr		2000	3,187		5			3,187	20
21		Safety Surfacing of Playground		2000	6,094		5			6,094	21
22		Landscaping of Playground land impr		2000	3,325		5			3,325	22
23		Improvements prior to 1996 fully depreciated			208,807		5			208,807	23
24		Building Construction Pod II		1973	615,786	17,009	40	17,009		573,247	24
25		Oxygen Work		1974	74,064	2,047	40	2,047		66,892	25
26		Oxygen Work		1975	5,000	135	40	135		4,382	26
27		Oxygen Work		1976	7,535	361	40	361		6,529	27
28		New Roof		1986	81,000		20			81,000	28
29		Lobby Addition		1984	108,605		25			108,605	29
30		Parents Room		1987	42,000		20			42,000	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		10			2,984	34
35		Water Heaters		1995	8,916		10			8,916	35
36		Vinyl Tile Flooring - Dental Office		1995	644		10			644	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:

07/01/08

Ending:

06/30/09

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	\$	5	\$	\$	\$ 605	37
38	Lobby walls	2000	57		5			57	38
39	Awnings rear entrance	2000	2,023		5			2,023	39
40	lower level classroom renovations	2000	183		5			183	40
41	awning for O2 protection	2000	3,477		5			3,477	41
42	Lobby walls	2000	4,997		5			4,997	42
43	HVAC-dining room	2000	610		5			610	43
44	Dining room walls & wall coverings	2000	2,060		5			2,060	44
45	HVAC coil dining room	2000	1,590		5			1,590	45
46	fire doors lower level	2000	564	56	10	56		536	46
47	carpet flooring lower level	1999	5,855		5			5,855	47
48	lower level classroom renovation	1999	1,346		5			1,346	48
49	replacement windows	1999	538		5			538	49
50	Construction, engineering, architect, inspection	1999	49,390	4,939	10	4,939		46,921	50
51	fire sprinkler system	1999	72,843	2,914	25	2,914		27,680	51
52	interior design, handrails, corner pieces	1999	29,873	1,992	15	1,992		18,919	52
53	Demolition old lower level	1999	26,641	2,664	10	2,664		25,309	53
54	Chair rails	1999	8,160		5			8,160	54
55	Wall Carpet	1998	4,887		5			4,887	55
56	Painting lower level	1999	19,835		5			19,835	56
57	lower level construction walls	1999	101,713	10,171	10	10,171		96,627	57
58	cabinets	1999	46,002	3,067	15	3,067		29,135	58
59	Reg. & auto doors	1999	18,259	1,826	10	1,826		17,346	59
60	Equip relocation	1999	2,495		5			2,495	60
61	Electrical work lower level	1999	29,697	2,970	10	2,970		28,212	61
62	windows/shutters	1999	15,529	1,553	10	1,553		15,529	62
63	Floor/carpeting	1999	46,503		5			46,503	63
64	Signage Interior/Exterior	1999	3,899	390	10	390		3,704	64
65	Plumbing lower level	1999	21,177	1,059	20	1,059		10,059	65
66	ECU Awnings	1999	3,994	266	15	266		2,530	66
67	Paneling	1999	7,309		5			7,309	67
68	Security System,Elevator	1999	11,010	734	15	734		6,973	68
69	New door hardware	1999	197	20	10	20		187	69
70	TOTAL (lines 4 thru 69)		\$ 1,889,836	\$ 54,327		\$ 54,327	\$	\$ 1,737,380	70

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

Facility Name & ID Number Marklund Children's Home

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	\$ 54,327		\$ 54,327	\$	\$ 1,737,380	1
2	Fire alarm system upper level	1999	12,491	500	25	500		4,747	2
3	Water Heater	2001	767		5			767	3
4	Air Curtain	2001	764		5			764	4
5	Replacement Parts - Boiler	2001	5,290		5			5,290	5
6	Compressor Pump	2001	1,599		5			1,599	6
7	Security Door	2001	2,427		5			2,427	7
8	New Flooring	2000	2,955		5			2,955	8
9	Roof Repair	1999	8,800		5			8,800	9
10	New compressor	1999	2,580	172	15	172		1,806	10
11	Awnings	1999	2,520		5			2,520	11
12	Boiler	1998	2,675		5			2,675	12
13	Plexiglass-reception area	2002	3,100		5			3,100	13
14	Stairwell Door replacements	2001	1,165		5			1,165	14
15	New Radiator for generator	2001	3,002		5			3,002	15
16	Sliding door repair	2002	4,179		5			4,179	16
17	Carpeting	2002	1,690		5			1,690	17
18	Awning	2002	2,694		5			2,694	18
19	Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571		5			15,571	19
20	Renovations: Architect, Engineering, reconstruct	2005	2,571,858	257,186	10	257,186		1,157,336	20
21	Renovations: Electrical work	2005	65,707	6,571	10	6,571		29,568	21
22	Renovations: Piping and Plumbing	2005	114,194	11,419	10	11,419		51,387	22
23	Renovations: Shelving	2005	1,118	112	10	112		503	23
24	Hot Water Heater	2005	4,529	906	5	906		4,076	24
25	Landscaping: plants, flowers, bushes	2005	4,055	811	5	811		3,650	25
26	Outdoor lighting, fencing, landscaping	2005	38,190	3,819	10	3,819		17,186	26
27	Exterior signage	2006	5,380	1,076	5	1,076		3,766	27
28	Dugout walls w/doors and jams	2006	13,671	2,734	5	2,734		9,570	28
29	Roof removal and replacement	2006	62,340	6,234	10	6,234		21,819	29
30	Fire door w/metal edge astragals w/door coordinators	2006	1,730	346	5	346		1,211	30
31	HVAC Roof repairs	2006	69,022	6,902	10	6,902		24,158	31
32	Electrical work for HVAC	2006	3,900	780	5	780		2,730	32
33	Asbestos tile and mastic removal exercise room	2006	2,950	590	5	590		2,065	33
34	TOTAL (lines 1 thru 33)		\$ 4,922,750	\$ 354,484		\$ 354,484	\$	\$ 3,132,155	34

**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 12B, Carried Forward		\$ 4,922,750	\$ 354,484		\$ 354,484	\$	\$ 3,132,155	1
2	Painting of 4 bedrooms	2006	3,875	775	5	775		2,713	2
3	Tree Removal/ Gravel/ Move Shed - Campsite	2007	1,150	230	5	230		575	3
4	MCH Campus Signs	2007	5,380	1,076	5	1,076		2,690	4
5	New Carpeting/Base Room 3	2007	4,420	884	5	884		2,210	5
6	Asbestos Consulting and Removal	2007	2,614	871	5	871		2,178	6
7	Sprinklers for Awnings	2008	2,400	480	5	480		720	7
8	Awnings	2008	7,826	1,565	5	1,565		2,348	8
9	Boiler Repair	2008	2,925	975	3	975		1,463	9
10	Electric Receptacles in Wiremold	2008	3,645	729	5	729		1,094	10
11	Sidewalk Repair	2008	3,300	660	5	660		990	11
12	Peace Pole Garden	2009	2,837	284	5	284		284	12
13	Insulate Windows / Re-install trim	2009	858	86	5	86		86	13
14	Installation of Wiremold Outlets	2009	1,036	104	5	104		104	14
15	Carpeting & Installation in Office Area	2009	5,500	550	5	550		550	15
16	Labor/ Material - Water Main Repair	2009	2,860	286	5	286		286	16
17	Installation / Rmoval of Ramp	2000	2,100		5			2,100	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	TOTAL (lines 1 thru 33)		\$ 4,975,476	\$ 364,039		\$ 364,039	\$	\$ 3,152,544	34

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

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	\$ 311,335	\$ 44,489	\$ 44,489	\$		\$ 215,172	71
72	Current Year Purchases	5,543	554	554			554	72
73	Fully Depreciated Assets	1,043,983					1,043,983	73
74								74
75	TOTALS	\$ 1,360,861	\$ 45,043	\$ 45,043	\$		\$ 1,259,709	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	Maintenance	2004 Isuzu Truck	2004	\$ 34,940	\$	\$	\$	4	\$ 34,940	76
77	Patient Transport	2006 Ford Eldorado Bus	2006	48,400	9,696	9,696		5	24,240	77
78	Courier	2007 Ford Focus	2007	13,427	2,685	2,685		5	6,713	78
79										79
80	TOTALS			\$ 96,767	\$ 12,381	\$ 12,381	\$		\$ 65,893	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)	\$ 6,464,605	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 421,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 421,463	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,478,147	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

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: \$ 7,661 Description: Office Equipment/Machinery

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Exceptional Care Program</u>		12264	309,666			100,937	12,264	410,603	12
13	Other (specify):									13
14	TOTAL			\$ 309,666		\$	\$ 100,937	12,264	\$ 410,603	14

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

Facility Name & ID Number Marklund Children's Home# 0011288Report Period Beginning: 07/01/08

Ending:

06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 394,282	\$ 394,282	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>164,000</u>)	3,744,419	3,744,419	3
4	Supply Inventory (priced at)	58,250	58,250	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	82,328	82,328	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	533,198	533,198	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,812,477	\$ 4,812,477	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,224,013	6,224,013	13
14	Buildings, at Historical Cost	21,280,368	21,280,368	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,688,789	4,688,789	16
17	Accumulated Depreciation (book methods)	(13,444,146)	(13,444,146)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,703,931	5,703,931	21
22	Other Long-Term Assets (specify):	2,998,355	2,998,355	22
23	Other(specify): <u>construction in progress</u>	2,090,560	2,090,560	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,541,870	\$ 29,541,870	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 34,354,347	\$ 34,354,347	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 536,232	\$ 536,232	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,046,980	1,046,980	29
30	Accrued Salaries Payable	381,341	381,341	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,244	34,244	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Compensation & Related Payables</u>	997,170	997,170	36
37	<u>Misc. Other</u>	3,090,637	3,090,637	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,086,604	\$ 6,086,604	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)	\$ 6,086,604	\$ 6,086,604	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,267,743	\$ 28,267,743	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 34,354,347	\$ 34,354,347	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,307,557	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,307,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(145,403)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	720,962	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 Income (loss)	(2,532,641)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,957,082)	17
	B. Transfers (Itemize):		
18	Transfer out of Restrcted Funds into Operations - Exp	(82,732)	18
19	Transfer out of Restrcted Funds into Operations - Capital	(440,130)	19
20	Transfer into Operations from Restricted Funds	440,130	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (82,732)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 28,267,743	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marklund Children's Home# 0011288Report Period Beginning: 07/01/08Ending: 06/30/09

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,256,535	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,256,535	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	28,198	5
6	Therapy		6
7	Oxygen	67,565	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 95,763	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	342,081	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 342,081	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,694,379	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	288,316	31
32	Health Care	987,542	32
33	General Administration	592,656	33
B. Capital Expense			
34	Ownership	429,124	34
C. Ancillary Expense			
35	Special Cost Centers	410,603	35
36	Provider Participation Fee	131,541	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,839,782	40
41	Income before Income Taxes (line 30 minus line 40)**	(145,403)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (145,403)	43

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

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

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

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

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

0011288

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	\$ 63,211	\$ 30.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,772	19,760	499,040	25.26	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	29,778	31,346	438,838	14.00	5
6	CNA Trainees					6
7	Licensed Therapist	1,363	1,435	44,007	30.67	7
8	Rehab/Therapy Aides	395	416	5,616	13.50	8
9	Activity Director					9
10	Activity Assistants	1,976	2,080	27,190	13.07	10
11	Social Service Workers	395	416	4,992	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,383	1,456	23,995	16.48	17
18	Housekeepers	4,940	5,200	48,256	9.28	18
19	Laundry	2,075	2,184	20,268	9.28	19
20	Administrator	1,976	2,080	77,210	37.12	20
21	Assistant Administrator					21
22	Other Administrative	2,371	2,496	52,189	20.91	22
23	Office Manager					23
24	Clerical	3,359	3,536	39,886	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,952	4,160	62,400	15.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	395	416	5,200	12.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	75,106	79,061	\$ 1,412,298 *	\$ 17.86	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	92	\$ 4,600	1	35
36	Medical Director	Monthly	29,732	9	36
37	Medical Records Consultant				37
38	Nurse Consultant			10	38
39	Pharmacist Consultant	Monthly	900	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	87	3,044	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	12	1,061	15	46
47	<u>Vision</u>	6	141	15	47
48	<u>Dental</u>	17	425	15	48
49	TOTAL (lines 35 - 48)	214	\$ 39,903		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,370	\$ 110,488	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	651	17,233	10	52
53	TOTAL (lines 50 - 52)	3,021	\$ 127,721		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lois Kramer	Administrator		\$ 77,210	Workers' Compensation Insurance	\$ 28,138	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,123	Advertising: Employee Recruitment	19,137	
				FICA Taxes	100,390	Health Care Worker Background Check		
				Employee Health Insurance	72,269	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA DUES	1,337	
				Pension	22,010	MISC. DUES/SUBSCRIPTIONS	422	
				Dental	7,272			
				Life Insurance	647			
				Long Term Disability	388			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,210	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 239,237		\$ 20,896		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	5,283
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,248	TOTAL		\$	TOTAL	\$ 5,283

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Marklund Children's Home# 0011288Report Period Beginning: 07/01/08Ending: 06/30/09**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 \$1337
- (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. \$ 15,317 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. \$ 131,541
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes,Sch.8 If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.