

Facility Name & ID Number Marklund Childrens Home

0011288 Report Period Beginning: 07/01/14 Ending: 06/30/15

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED	7,030	365		7,395
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	7,030	365		7,395

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.53%

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

9 (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: 06/30/15 Fiscal Year: 06/30/15

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

Facility Name & ID Number

Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary		534	4,263	4,797		4,797		4,797		1
2	Food Purchase		52,053		52,053		52,053		52,053		2
3	Housekeeping	81,962	11,563	50	93,575		93,575		93,575		3
4	Laundry	27,231	5,178		32,409		32,409		32,409		4
5	Heat and Other Utilities			58,513	58,513		58,513		58,513		5
6	Maintenance	42,704	6,875	41,495	91,074		91,074		91,074		6
7	Other (specify):* Disposal Services			6,655	6,655		6,655		6,655		7
8	TOTAL General Services	151,897	76,203	110,976	339,076		339,076		339,076		8
	B. Health Care and Programs										
9	Medical Director			27,484	27,484		27,484		27,484		9
10	Nursing and Medical Records	1,160,391	142,857	102,235	1,405,483	(908,793)	496,690		496,690		10
10a	Therapy	86,322	769	2,771	89,862		89,862		89,862		10a
11	Activities	21,740	6,238		27,978		27,978		27,978		11
12	Social Services	6,660			6,660		6,660		6,660		12
13	CNA Training										13
14	Program Transportation	6,427		16,577	23,004		23,004		23,004		14
15	Other (specify):* Vision, Dental, Pharmacy & Pysch consultants			4,064	4,064		4,064		4,064		15
16	TOTAL Health Care and Programs	1,281,540	149,864	153,131	1,584,535	(908,793)	675,742		675,742		16
	C. General Administration										
17	Administrative	94,494			94,494		94,494		94,494		17
18	Directors Fees										18
19	Professional Services			10,354	10,354		10,354		10,354		19
20	Dues, Fees, Subscriptions & Promotions			17,330	17,330		17,330	(6,280)	11,050		20
21	Clerical & General Office Expenses	52,473	53,775	14,100	120,348	(14,014)	106,334		106,334		21
22	Employee Benefits & Payroll Taxes			338,908	338,908		338,908		338,909		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,172	6,172		6,172	(6,172)			24
25	Other Admin. Staff Transportation			7,130	7,130		7,130	(7,130)			25
26	Insurance-Prop.Liab.Malpractice			42,236	42,236		42,236		42,236		26
27	Other (specify):*			2,500	2,500		2,500	(2,500)			27
28	TOTAL General Administration	146,967	53,775	438,730	639,472	(14,014)	625,458	(22,082)	603,377		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,580,404	279,842	702,837	2,563,083	(922,807)	1,640,276	(22,082)	1,618,195		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 Childrens Home

#0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

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			392,783	392,783		392,783	(12,356)	380,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,201	3,201		3,201	(3,201)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			16,652	16,652		16,652	(16,652)				34
35	Rent-Equipment & Vehicles					14,014	14,014		14,014			35
36	Other (specify):*											36
37	TOTAL Ownership			412,636	412,636	14,014	426,650	(32,209)	394,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					908,793	908,793		908,793			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,215	137,215		137,215		137,215			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			137,215	137,215	908,793	1,046,008		1,046,008			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,580,404	279,842	1,252,688	3,112,934		3,112,934	(54,291)	3,058,644			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 Childrens Home

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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	(3,201)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,280)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,500)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(42,310)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,291)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (54,291)		37

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

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

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

Marklund Childrens Home

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Report Period Beginning: 07/01/14

Ending: 06/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Seminars	\$ (6,172)	24	1
2	Travel & Sustenance	(7,130)	25	2
3	Depreciation	(12,356)	30	3
4	Real Estate Taxes		33	4
5	Rent	(16,652)	34	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(42,310)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Childrens Home# 0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,280)	0	0	0	0	0	0	0	0	0	0	(6,280)	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	(6,172)	0	0	0	0	0	0	0	0	0	0	(6,172)	24
25	Other Admin. Staff Transportation	(7,130)	0	0	0	0	0	0	0	0	0	0	(7,130)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	27
28	TOTAL General Administration	(22,082)	0	(22,082)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,082)	0	(22,082)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14 Ending:

06/30/15

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,356)	0	0	0	0	0	0	0	0	0	0	(12,356)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,201)	0	0	0	0	0	0	0	0	0	0	(3,201)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(16,652)	0	0	0	0	0	0	0	0	0	0	(16,652)	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	(32,209)	0	(32,209)	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)	(54,291)	0	0	0	0	0	0	0	0	0	0	(54,291)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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 Childrens Home # 0011288 Report Period Beginning: 07/01/14 Ending: 06/30/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Marklund Childrens Home

0011288 Report Period Beginning: 07/01/14 Ending: 06/30/15

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	Direct Cost Budget	15,635,353	15,635,353	\$ 53	1,383,266	\$ 5	1
2	2	Food	Direct Cost Budget	15,635,353	15,635,353	737	1,383,266	65	2
3	3	Housekeeping	Direct Cost Budget	15,635,353	15,635,353	4,211	1,383,266	373	3
4	5	Utilities	Direct Cost Budget	15,635,353	15,635,353	52,857	1,383,266	4,676	4
5	6	Maintenance	Direct Cost Budget	15,635,353	15,635,353	16,478	1,383,266	1,458	5
6	7	Disposal	Direct Cost Budget	15,635,353	15,635,353	3,664	1,383,266	324	6
7	13	BNATP	Direct Cost Budget	15,635,353	15,635,353	0	1,383,266	0	7
8	14	Transportation	Direct Cost Budget	15,635,353	15,635,353	6,522	1,383,266	577	8
9	19	Professional Services	Direct Cost Budget	15,635,353	15,635,353	48,000	1,383,266	4,247	9
10	20	Fees,Subscription	Direct Cost Budget	15,635,353	15,635,353	56,431	1,383,266	4,992	10
11	21	Clerical/Office	Direct Cost Budget	15,635,353	15,635,353	172,201	1,383,266	15,235	11
12	22	Benefits	Direct Cost Budget	15,635,353	15,635,353	89,292	1,383,266	7,900	12
13	24	Travel & Seminar	Direct Cost Budget	15,635,353	15,635,353	8,920	1,383,266	789	13
14	25	Staff Transportation	Direct Cost Budget	15,635,353	15,635,353	10,512	1,383,266	930	14
15	26	Insurance	Direct Cost Budget	15,635,353	15,635,353	22,745	1,383,266	2,012	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 492,623	\$	\$ 43,583	25

Facility Name & ID Number

Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

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		3	4	5	6		8	9	10					
		Related**					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						\$	\$			\$					
2																
3																
4																
5																
Working Capital																
6	N/A															
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
B. Non-Facility Related*																
10	N/A															
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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 2014 report.		\$ <u>N/A</u>	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).		\$ <u>#VALUE!</u>	3																																	
4. Real Estate Tax accrual used for 2015 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.		\$ <u>#VALUE!</u>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2014	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2010	_____	8																																		
2011	_____	9																																		
2012	_____	10																																		
2013	_____	11																																		
2014	_____	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2014	\$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marklund Childrens Home COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0011288

CONTACT PERSON REGARDING THIS REPORT Kudus Badmus

TELEPHONE (630) 593-5487 FAX #: (630) 593-5501

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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.	<u>02-14-301-031</u>	<u>Residential - Tax exempt</u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Marklund Childrens Home

0011288 Report Period Beginning:

07/01/14 Ending:

06/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

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

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

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

Marklund Day School

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	30	1968	1953	\$ 68,500	\$	33	\$	\$	\$ 68,500
5									
6									
7									
8									
Improvement Type**									
9	LI Parking Lot Concrete Asphalt land impr		1999	300		5			300
10	LI Parking Lot Concrete Asphalt land impr		1999	32,199		5			32,199
11	LI Parking Lot Concrete Asphalt land impr		2000	300		5			300
12	LI Resurface Playground land impr		2000	7,750		5			7,750
13	LI Safety Surfacing of Playground		2000	6,094		5			6,094
14	LI Landscaping of Playground land impr		2000	3,325		5			3,325
15	BI Awnings rear entrance		2000	2,023		5			2,023
16	BI lower level classroom renovations		2000	183		5			183
17	BI awning for O2 protection		2000	3,477		5			3,477
18	BI fire doors lower level		2000	564		10			564
19	BI carpet flooring lower level		1999	5,855		5			5,855
20	BI lower level classroom renovation		1999	1,346		5			1,346
21	BI replacement windows		1999	538		5			538
22	BI Construction, engineering, architect, inspection		1999	49,390		10			49,390
23	BI fire sprinkler system		1999	72,843	2,914	25	2,914		45,163
24	BI interior design, handrails, corner pieces		1999	29,873	996	15	996		29,873
25	BI Demolition old lower level		1999	26,641		10			26,641
26	BI Chair rails		1999	8,160		5			8,160
27	BI Painting lower level		1999	19,835		5			19,835
28	BI lower level construction walls		1999	101,713		10			101,713
29	BI cabinets		1999	46,002	1,533	15	1,533		46,002
30	BI Reg. & auto doors		1999	18,259		10			18,259
31	BI Electrical work lower level		1999	29,697		10			29,697
32	BI windows/shutters		1999	15,529		10			15,529
33	BI Floor/carpeting		1999	46,503		5			46,503
34	BI Signage Interior/Exterior		1999	3,899		10			3,899
35	BI Plumbing lower level		1999	21,177	1,059	20	1,059		16,412
36	BI ECU Awnings		1999	3,994	133	15	133		3,994

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BI Paneling	1999	\$ 7,309	\$	5	\$	\$	\$ 7,309	37
38	BI Security System,Elevator	1999	11,010	367	15	367		11,010	38
39	BI New door hardware	1999	197		10			197	39
40	BI Fire alarm system upper level	1999	12,491	500	25	500		7,744	40
41	BI Water Heater	2001	767		5			767	41
42	BI Air Curtain	2001	764		5			764	42
43	BI Replacement Parts - Boiler	2001	3,858		5			3,858	43
44	BI Compressor Pump	2001	1,599		5			1,599	44
45	BI Security Door	2001	2,427		5			2,427	45
46	BI Roof Repair	1999	8,800		5			8,800	46
47	BI New compressor	1999	2,580		15			2,580	47
48	BI Boiler	1998	2,675		5			2,675	48
49	BI Stairwell Door replacements	2001	1,165		5			1,165	49
50	BI New Radiator for generator	2001	3,002		5			3,002	50
51	BI Sliding door repair	2002	4,179		5			4,179	51
52	BI Carpeting	2002	1,690		5			1,690	52
53	BI Awning	2002	2,694		5			2,694	53
54	LI Concrete Pads for Oxygen, Chiller, and Garbage	2002	15,571		5			15,571	54
55	BI Renovations: Architect, Engineering, reconstruct	2005	2,571,858	128,593	10	128,593		2,571,858	55
56	BI Renovations: Electrical work	2005	65,707	3,285	10	3,285		65,707	56
57	BI Renovations: Piping and Plumbing	2005	114,194	5,710	10	5,710		114,194	57
58	BI Renovations: Shelving	2005	1,118	56	10	56		1,118	58
59	BI Hot Water Heater	2005	4,529		5			4,529	59
60	LI Landscaping: plants, flowers, bushes	2005	4,055		5			4,055	60
61	LI Outdoor lighting, fencing, landscaping	2005	38,190	1,910	10	1,910		38,190	61
62	LI Exterior signage	2006	5,380		5			5,380	62
63	BI Dugout walls w/doors and jams	2006	13,671		5			13,671	63
64	BI Roof removal and replacement	2006	62,340	6,234	10	6,234		59,223	64
65	BI Fire door w/metal edge astragals w/door coordinators	2006	1,730		5			1,730	65
66	BI HVAC Roof repairs	2006	69,022	6,902	10	6,902		65,571	66
67	BI Electrical work for HVAC	2006	3,900		5			3,900	67
68	BI Asbestos tile and mastic removal exercise room	2006	2,950		5			2,950	68
69	BI Painting of 4 bedrooms	2006	3,875		5			3,875	69
70	TOTAL (lines 4 thru 69)		\$ 3,671,266	\$ 160,191		\$ 160,191	\$	\$ 3,627,507	70

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,671,266	\$ 160,191		\$ 160,191	\$	\$ 3,627,507	1
2	LI Tree Removal/ Gravel/ Move Shed - Campsite	2007	1,150		5			1,150	2
3	LI MCH Campus Signs	2007	5,380		5			5,380	3
4	BI New Carpeting/Base Room 3	2007	4,420		5			4,420	4
5	BI Asbestos Consulting and Removal	2007	2,614		3			2,614	5
6	BI Sprinklers for Awnings	2008	2,400		5			2,400	6
7	BI Awnings	2008	7,826		5			7,826	7
8	BI Boiler Repair	2008	2,925		3			2,925	8
9	BI Electric Receptacles in Wiremold	2008	3,645		5			3,645	9
10	LI Sidewalk Repair	2008	3,300		5			3,300	10
11	LI Peace Pole Garden	2009	2,837		5			2,837	11
12	BI Insulate Windows / Re-install trim	2009	858		5			858	12
13	BI Installation of Wiremold Outlets	2009	1,036		5			1,036	13
14	BI Carpeting & Installation in Office Area	2009	5,500		5			5,500	14
15	BI Labor/ Material - Water Main Repair	2009	2,860		5			2,860	15
16	BI Tie doors into Fire System	2009	1,695		5			1,695	16
17	LI Driveway Reconstruction	2010	88,608	8,394	10	8,394		50,833	17
18	LI (2) 10'-12' Spruce Trees	2010	4,375	438	5	438		4,375	18
19	LI Trash enclosure w/ornamental Fencing	2010	6,295	630	5	630		6,295	19
20	LI Earthwork	2010	33,414	3,166	10	3,166		19,169	20
21	LI Fences and Gates	2010	2,310	231	5	231		2,310	21
22	LI Sealcoating and striping of Driveway	2010	2,451		2			2,451	22
23	LI Trees, shrubs, misc planting	2010	10,240	1,024	5	1,024		10,240	23
24	LI (4) Fat Albert Colorado Blue Spruce Trees	2010	1,660	166	5	166		1,660	24
25	BI Gutter replacement	2010	1,592	159	5	159		1,592	25
26	BI Construction/Plumbing Dental lines	2010	143,610	6,996	20	6,996		42,162	26
27	BI Demo/Bldg, Flooring, Masonry, Alarm service	2010	75,010	3,654	20	3,654		22,022	27
28	BI Const/Drywall, Painting, Insulation	2010	98,198	4,784	20	4,784		28,830	28
29	BI Const/Skylights, Door frames, Entrances	2010	111,060	5,411	20	5,411		32,606	29
30	BI Architect, Plans, Surveys, Consults	2010	171,381	8,349	20	8,349		50,316	30
31	BI Structural/Eng Consults, Plans, Reviews	2010	72,963	3,555	20	3,555		21,421	31
32	BI Constructon: Damproofing/Water Protection	2010	7,275	728	10	728		4,001	32
33	BI Construction Electrical Work	2010	282,582	13,767	20	13,767		82,963	33
34	TOTAL (lines 1 thru 33)		\$ 4,832,736	\$ 221,642		\$ 221,642	\$	\$ 4,059,200	34

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,832,736	\$ 221,642		\$ 221,642	\$	\$ 4,059,200	1
2	BI Construction:Masonry, Concrete,Steel, Roofing	2010	238,586	11,623	20	11,623		70,047	2
3	BI Installation: Blinds and Shades	2010	10,054	1,005	10	1,005		5,529	3
4	BI Construction:Vinyl Flooring, Carpeting	2010	60,995	6,100	10	6,100		33,547	4
5	BI Construction: General Conditions	2010	330,889	16,120	20	16,120		97,146	5
6	BI Installation of Cabinetry	2010	1,990	199	10	199		1,095	6
7	BI Construction:Heating,Ventilation,Elevator	2010	335,130	16,327	20	16,327		98,391	7
8	BI Air Testing, Monitoring, Reporting	2010	3,420	342	10	342		1,881	8
9	BI Construction: Fire Protection System	2010	85,492	8,549	10	8,549		47,021	9
10	BI Construction:Carpentry	2010	341,102	16,618	20	16,618		100,144	10
11	BI Connect back-up Phone, Door	2010	4,800	480	5	480		4,800	11
12	BI Tuckpointing/Restoration to Chimney Stack	2010	3,475	348	5	348		3,475	12
13	LI 12" Drain, Drain Tile Connect Culvert to Sewer	2011	5,070	1,014	5	1,014		4,563	13
14	LI Gable Style Awning Over Oxvgen Storage	2011	1,296	259	5	259		1,166	14
15	BI Hot Water Heater	2011	1,753	351	5	351		1,577	15
16	BI Gutter & Downspout Repairs	2011	1,220	244	5	244		1,098	16
17	BI Replacement of Wall Carpeting	2011	2,980	596	5	596		2,682	17
18	BI Exterior Handrail	2012	1,250	250	5	250		875	18
19	LI Refurbishing of Exterior Signs	2012	6,100	1,220	5	1,220		4,270	19
20	LI Asphalt Repairs to Driveway	2012	825	165	5	165		578	20
21	LI Landscaping/installation of Catch Basin Drainage	2012	4,535	907	5	907		3,175	21
22	BI Surge Suppression System	2013	2,583	517	5	517		1,291	22
23	LI 220LF of Barrier Curb	2013	7,902	790	5	790		1,976	23
24	LI 70 SF Unilock Stack Stone (Split)	2013	3,780	756	5	756		1,890	24
25	BI Rubber Floor Replacement	2014	624	125	5	125		187	25
26	BI HM Replacement Door set	2014	2,883	577	5	577		865	26
27	BIInstallation of Bi-Fold Door	2015	1,925	193	5	193		193	27
28	LI Refurburbish/ Revise Outdoor Sign	2015	2,467	247	5	247		247	28
29	LI Sidewalk Dumpster Pad ADA Ramps Concerte	2015	12,200	610	10	610		610	29
30	LI Concrete Walk to Connect Park District	2015	1,050	53	10	53		53	30
31	LI Asphalt Driveway Renovation	2015	60,950	3,048	10	3,048		3,048	31
32	LI Sidewalk Railings	2015	1,450	73	10	73		73	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,371,510	\$ 311,344		\$ 311,344	\$	\$ 4,552,689	34

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 6,371,510	\$ 311,344		\$ 311,344	\$	\$ 4,552,689	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		\$ 6,371,510	\$ 311,344		\$ 311,344	\$	\$ 4,552,689	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 323,301	\$ 47,334	\$ 47,334	\$		\$ 240,899	71
72	Current Year Purchases	129,276	9,370	9,370			9,370	72
73	Fully Depreciated Assets	703,654					703,654	73
74								74
75	TOTALS	\$ 1,156,230	\$ 56,705	\$ 56,705	\$		\$ 953,923	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2012 Ford F-250 Box Truck	2012	\$ 38,315	\$ 7,774	\$ 7,774	\$	5	\$ 26,653	76
77	Patient Transport	2006 Ford Rel Dorado Bus	2006	48,480				5	48,480	77
78	Courier	2013 Ford Transit Connect	2013	23,020	4,604	4,604		5	11,510	78
79	Patient Transport	2009 Ford Mobility Van	2009	34,475				5	34,475	79
80	TOTALS			\$ 144,290	\$ 12,378	\$ 12,378	\$		\$ 121,119	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,703,531	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 380,427	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 380,427	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)	\$ 5,627,731	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning: 07/01/14

Ending: 06/30/15

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 14,014 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 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>Exceptional Care Programs</u>		25080	765,936			142,857	25,080	908,793	12	
13	Other (specify):									13	
14	TOTAL			\$ 765,936		\$	\$ 142,857	25,080	\$ 908,793	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 Childrens Home

0011288

Report Period Beginning: 07/01/14

Ending:

06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15 (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	\$ 708,174	\$ 708,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>234,000</u>)	2,764,757	2,764,757	3
4	Supply Inventory (priced at)	87,943	87,943	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	270,947	270,947	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	692,889	692,889	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,524,710	\$ 4,524,710	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	6,545,264	6,545,264	13
14	Buildings, at Historical Cost	23,376,619	23,376,619	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,458,710	5,458,710	16
17	Accumulated Depreciation (book methods)	(20,106,391)	(20,106,391)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	9,863,824	9,863,824	21
22	Other Long-Term Assets (specify):	6,059,674	6,059,674	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,197,700	\$ 31,197,700	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 35,722,410	\$ 35,722,410	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 513,048	\$ 513,048	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,516	254,516	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,054	20,054	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>	266,981	266,981	36
37	<u>misc. other</u>	1,704,934	1,704,934	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,759,533	\$ 2,759,533	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)	\$ 2,759,533	\$ 2,759,533	46
47	TOTAL EQUITY(page 18, line 24)	\$ 32,962,877	\$ 32,962,877	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 35,722,410	\$ 35,722,410	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 32,954,931	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,954,931	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(808,339)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,569,088	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) <u>Remaining Consolidated Income</u>	(1,034,751)	15
16	Other (describe) <u>loss on disposal of building & equipment</u>	(21,109)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (295,111)	17
B. Transfers (Itemize):			
18	<u>Transfers out of Restricted Funds into Operations- exp.</u>	303,057	18
19	<u>Transfers out of Restricted Funds into Operations-capital</u>	453,387	19
20	<u>Transfers into Operations from Restricted Funds</u>	(453,387)	20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 303,057	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 32,962,877	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 2,304,595		1
2	Discounts and Allowances for all Levels	()		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,304,595		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			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			24
25	Interest and Other Investment Income***			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$		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)	\$ 2,304,595		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	339,076		31
32	Health Care	1,584,535		32
33	General Administration	639,472		33
B. Capital Expense				
34	Ownership	412,636		34
C. Ancillary Expense				
35	Special Cost Centers			35
36	Provider Participation Fee	137,215		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,112,934		40
41	Income before Income Taxes (line 30 minus line 40)**	(808,339)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (808,339)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,155,794	44
45	Private Pay - Net Inpatient Revenue	148,801	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,304,595	49

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

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

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

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

Facility Name & ID Number Marklund Childrens Home

0011288

Report Period Beginning: 07/01/14

Ending: 06/30/15

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	\$ 91,728	\$ 44.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,863	18,803	574,332	30.54	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	28,790	30,306	447,008	14.75	5
6	CNA Trainees					6
7	Licensed Therapist	2,016	2,122	80,324	37.85	7
8	Rehab/Therapy Aides	395	416	5,999	14.42	8
9	Activity Director					9
10	Activity Assistants	1,482	1,560	21,740	13.94	10
11	Social Service Workers	395	416	6,660	16.01	11
12	Dietician					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	42,704	29.33	17
18	Housekeepers	7,015	7,384	81,962	11.10	18
19	Laundry	2,569	2,704	27,231	10.07	19
20	Administrator	1,976	2,080	94,494	45.43	20
21	Assistant Administrator					21
22	Other Administrative	20	21	1,278	60.86	22
23	Office Manager					23
24	Clerical	2,766	2,912	51,193	17.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,976	2,080	42,868	20.61	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	316	333	4,456	13.38	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,432	75,193	\$ 1,580,404 *	\$ 21.02	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	85	\$ 4,263	1	35
36	Medical Director	monthly	27,484	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,244	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	40	2,771	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	15	1,233	15	46
47	<u>Vision</u>	25	563	15	47
48	<u>Dental</u>	41	1,025	15	48
49	TOTAL (lines 35 - 48)	206	\$ 38,583		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6	\$ 80,028	10	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		22,207	10	52
53	TOTAL (lines 50 - 52)	6	\$ 102,235		53

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

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

Facility Name & ID Number Marklund Childrens Home# 0011288Report Period Beginning: 07/01/14Ending: 06/30/15**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 , \$1260
- (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. \$ 16,487 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. \$ 137,215
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

<u>Type</u>	<u>Manufacturer</u>	<u>Model</u>	<u>Qty</u>
Copier	Minolta	BizHub 224E	1
Copier	Minolta	BizHub C224E	1
Copier	Minolta	BizHub C454E	1