



Facility Name & ID Number Marklund Childrens Home

# 0011288 Report Period Beginning: 07/01/16 Ending: 06/30/2017

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	21	Skilled Pediatric (SNF/PED)	21	7,665	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	21	TOTALS	21	7,665	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	7,550			7,550	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,550			7,550	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 98.50%

**D. How many bed reserve days during this year were paid by the Department?**  
24 (Do not include bed reserve days in Section B.)

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

**F. Does the facility maintain a daily midnight census?** yes

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

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**  
YES  NO

**I. On what date did you start providing long term care at this location?**  
Date started 10/01/68

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date \_\_\_\_\_ NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number Marklund Childrens Home # 0011288 Report Period Beginning: 07/01/16 Ending: 06/30/2017

**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
	<b>A. General Services</b>										
1	Dietary		294	3,650	3,944		3,944		3,944		1
2	Food Purchase		39,155		39,155		39,155		39,155		2
3	Housekeeping	81,962	11,182	3,865	97,009		97,009		97,009		3
4	Laundry	27,231	5,184		32,415		32,415		32,415		4
5	Heat and Other Utilities			55,946	55,946		55,946		55,946		5
6	Maintenance	30,503	8,138	36,831	75,472		75,472		75,472		6
7	Other (specify):* <b>Disposal Services</b>			4,444	4,444		4,444		4,444		7
8	<b>TOTAL General Services</b>	139,696	63,953	104,736	308,385		308,385		308,385		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,484	27,484		27,484		27,484		9
10	Nursing and Medical Records	1,167,132	170,030	131,708	1,468,870	(1,044,603)	424,267		424,267		10
10a	Therapy	59,257	552	4,410	64,219		64,219		64,219		10a
11	Activities	29,540	8,819		38,359		38,359		38,359		11
12	Social Services	6,660			6,660		6,660		6,660		12
13	CNA Training										13
14	Program Transportation	6,427		31,596	38,023		38,023		38,023		14
15	Other (specify):* <b>Vision, Dental, Pharmacy &amp; Pysch consultants</b>			3,539	3,539		3,539		3,539		15
16	<b>TOTAL Health Care and Programs</b>	1,269,016	179,401	198,737	1,647,154	(1,044,603)	602,551		602,551		16
	<b>C. General Administration</b>										
17	Administrative	94,494			94,494		94,494		94,494		17
18	Directors Fees										18
19	Professional Services			9,922	9,922		9,922		9,922		19
20	Dues, Fees, Subscriptions & Promotions			12,452	12,452		12,452	(297)	12,155		20
21	Clerical & General Office Expenses	46,559	55,201	19,311	121,071	(13,570)	107,501		107,501		21
22	Employee Benefits & Payroll Taxes			370,006	370,006		370,006		370,006		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,378	3,378		3,378	(3,378)			24
25	Other Admin. Staff Transportation			5,293	5,293		5,293	(5,293)			25
26	Insurance-Prop.Liab.Malpractice			25,473	25,473		25,473		25,473		26
27	Other (specify):* <b>bad debt</b>			2,500	2,500		2,500	(2,500)			27
28	<b>TOTAL General Administration</b>	141,053	55,201	448,335	644,589	(13,570)	631,019	(11,468)	619,551		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,549,765	298,555	751,808	2,600,128	(1,058,173)	1,541,955	(11,468)	1,530,487		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 &amp; ID Number

Marklund Childrens Home

#0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			230,564	230,564		230,564	(13,738)	216,826			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,375	8,375		8,375	(8,375)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					13,570	13,570		13,570			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			238,939	238,939	13,570	252,509	(22,113)	230,396			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,044,603	1,044,603		1,044,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,009	144,009		144,009		144,009			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			144,009	144,009	1,044,603	1,188,612		1,188,612			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,549,765	298,555	1,134,756	2,983,076		2,983,076	(33,581)	2,949,495			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	(8,375)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(297)	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	(22,410)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (33,582)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (33,582)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Marklund Childrens Home

ID# 0011288

Report Period Beginning: 07/01/16

Ending: 06/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Seminars	\$ (3,378)	24	1
2	Travel & Sustenance	(5,293)	25	2
3	Depreciation	(13,738)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(22,409)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
<b>B. Health Care and Programs</b>														
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
<b>C. General Administration</b>														
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	(297)	0	0	0	0	0	0	0	0	0	0	(297)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,378)	0	0	0	0	0	0	0	0	0	0	(3,378)	24
25	Other Admin. Staff Transportation	(5,293)	0	0	0	0	0	0	0	0	0	0	(5,293)	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	<b>TOTAL General Administration</b>	(11,468)	0	0	0	0	0	0	0	0	0	0	(11,468)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(11,468)	0	0	0	0	0	0	0	0	0	0	(11,468)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

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	(13,738)	0	0	0	0	0	0	0	0	0	0	(13,738)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,375)	0	0	0	0	0	0	0	0	0	0	(8,375)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(22,113)</b>	<b>0</b>	<b>(22,113)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(33,581)</b>	<b>0</b>	<b>(33,581)</b>	<b>45</b>									

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

## 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

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Report Period Beginning:

07/01/16

Ending: 6/30/2017

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	20,686,983	20,686,983	\$ 0	\$ 2,700,264	\$ 0	1
2	2	Food	Direct Cost Budget	20,686,983	20,686,983	789	2,700,264	103	2
3	3	Housekeeping	Direct Cost Budget	20,686,983	20,686,983	4,832	2,700,264	631	3
4	5	Utilities	Direct Cost Budget	20,686,983	20,686,983	28,825	2,700,264	3,763	4
5	6	Maintenance	Direct Cost Budget	20,686,983	20,686,983	15,024	2,700,264	1,961	5
6	7	Disposal	Direct Cost Budget	20,686,983	20,686,983	876	2,700,264	114	6
7	13	BNATP	Direct Cost Budget	20,686,983	20,686,983	0	2,700,264	0	7
8	14	Transportation	Direct Cost Budget	20,686,983	20,686,983	789	2,700,264	103	8
9	19	Professional Services	Direct Cost Budget	20,686,983	20,686,983	63,600	2,700,264	8,302	9
10	20	Fees,Subscription	Direct Cost Budget	20,686,983	20,686,983	81,708	2,700,264	10,665	10
11	21	Clerical/Office	Direct Cost Budget	20,686,983	20,686,983	280,917	2,700,264	36,668	11
12	22	Benefits	Direct Cost Budget	20,686,983	20,686,983	82,603	2,700,264	10,782	12
13	24	Travel & Seminar	Direct Cost Budget	20,686,983	20,686,983	14,964	2,700,264	1,953	13
14	25	Staff Transportation	Direct Cost Budget	20,686,983	20,686,983	7,882	2,700,264	1,029	14
15	26	Insurance	Direct Cost Budget	20,686,983	20,686,983	31,602	2,700,264	4,125	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 614,411	\$	\$ 80,199	25

Facility Name & ID Number

Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

**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		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	N/A						\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	N/A											6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9						
<b>B. Non-Facility Related*</b>																		
10	N/A											10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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 Childrens Home

# 0011288 Report Period Beginning:

07/01/16 Ending:

06/30/2017

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? [X] (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? [X] (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 [X] 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for index. Row 1: Patient care, 206,930, 1968, \$ 31,500, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 206,930, (blank), \$ 31,500, 3.

Facility Name &amp; ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

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**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	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	LI Parking Lot Concrete Asphalt		1999	300		5			300	9
10	LI Parking Lot Concrete Asphalt		1999	32,199		5			32,199	10
11	LI Parking Lot Concrete Asphalt		2000	300		5			300	11
12	LI Resurface Playground		2000	7,750		5			7,750	12
13	LI Safety Surfacing		2000	6,094		5			6,094	13
14	LI Landscaping of Playground		2000	3,325		5			3,325	14
15	BI Awnings Rear Entrance		2000	2,023		5			2,023	15
16	BI Lower Level Classroom Renovatons		2000	183		5			183	16
17	BI Awning for Oxygen Protection		2000	3,477		5			3,477	17
18	BI fire doors lower level		2000	564		10			564	18
19	BI carpet flooring lower level		1999	5,855		5			5,855	19
20	BI Lower Level Classroom Renovatons		1999	1,346		5			1,346	20
21	BI replacement windows		1999	538		5			538	21
22	BI construction, engineering, architect, inspection		1999	49,390		10			49,390	22
23	BI fire sprinkler system		1999	72,843	2,914	25	2,914		50,990	23
24	BI inerior design, handrails, corner pieces		1999	29,873		15			29,873	24
25	BI demolition old lwer level		1999	26,641		10			26,641	25
26	BI chair rails		1999	8,160		5			8,160	26
27	BI painting Lower level		1999	19,835		5			19,835	27
28	BI lower level construction walla		1999	101,713		10			101,713	28
29	BI cabinets		1999	46,002		15			46,002	29
30	BI reg. & ato doors		1999	18,259		10			18,259	30
31	BI electrical work lower level		1999	29,697		10			29,697	31
32	BI window shutters		1999	15,529		10			15,529	32
33	BI floor/carpeting		1999	46,503		5			46,503	33
34	BI signage-nterior/exterior		1999	3,899		10			3,899	34
35	BI plumbiong lower level		1999	21,177	1,059	20	1,059		18,530	35
36	ECU awnings		1999	3,994		15			3,994	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 &amp; ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

## 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		15			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		8,744	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, reconstruction	2005	2,571,858		10			2,571,858	55
56	BI renovations: electrical work	2005	65,707		10			65,707	56
57	BI renovations: piping and plumbing	2005	114,194		10			114,194	57
58	BI renovations: shelving	2005	1,118		10			1,118	58
59	BI hot water heater	2005	4,529		5			4,529	59
60	landscaping: plants, flowers, bushes	2005	4,055		5			4,055	60
61	LI outdoor lighting	2005	38,190		10			38,190	61
62	LI exterior signage	2006	5,380		5			5,380	62
63	BI dugout walls w/door and jams	2006	13,671		5			13,671	63
64	BI roof removal and replacement	2006	62,340		10			62,340	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		10			69,022	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	\$ 4,472		\$ 4,472	\$	\$ 3,643,019	70

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

Facility Name &amp; ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,671,266	\$ 4,472		\$ 4,472	\$	\$ 3,643,019	1
2	LI tree removal/gravel/move shed-campsite	2007	1,150		5			1,150	2
3	LI campus signs	2007	5,380		5			5,380	3
4	BI new carpeting /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 electrical receptacles in wiremold	2008	3,645		5			3,645	9
10	LI sidewalk repair	2008	3,300		5			3,300	10
11	LI peace ole garden	2009	2,837		5			2,837	11
12	BI insulate windows /re-install trim	2009	858		5			858	12
13	BI installaton of wiremold outlets	2009	1,036		5			1,036	13
14	BI carpeting amd 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 reconstructiu	2010	88,608	8,394	10	8,394		67,622	17
18	LI (2) 10"-12" spruce trees	2010	4,375		5			4,375	18
19	LI trash enclosure w/ornamental fencing	2010	6,295		5			6,295	19
20	LI earthwork	2010	33,414	3,166	10	3,166		25,500	20
21	LI faences and gates	2010	2,310		5			2,310	21
22	LI sealcoating and striping of driveway	2010	2,451		2			2,451	22
23	LI trees, shrubs, miisc planting	2010	10,240		5			10,240	23
24	LI (4) fat albert colorado spruce trees	2010	1,660		5			1,660	24
25	BI gutter replacement	2010	1,592		5			1,592	25
26	BI construction: plumbing for dental lines	2010	143,610	6,996	20	6,996		56,155	26
27	BI demo: bldg, flooring, masonry, alarm service	2010	75,010	3,654	20	3,654		29,331	27
28	BI construction: drywall, painting, insulation	2010	98,198	4,784	20	4,784		38,398	28
29	BI conctruction: skylights,door frames, emntrances	2010	111,060	5,411	20	5,411		43,427	29
30	BI architect, plands, surveys, conults	2010	171,381	8,349	20	8,349		67,014	30
31	BI costrcutuon: structural engeeting consults/plan reviews	2010	72,963	3,555	20	3,555		28,530	31
32	BI constrcutiion: damproofing/water protection	2010	7,275	728	10	728		5,456	32
33	BI electrical work	2010	282,582	13,767	20	13,767		110,497	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,832,736	\$ 63,276		\$ 63,276	\$	\$ 4,192,319	34

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

Facility Name &amp; ID Number Marklund Childrens Home

# 0011288

Report Period Beginning:

07/01/16

Ending:

06/30/2017

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,832,736	\$ 63,276		\$ 63,276	\$	\$ 4,192,319	1
2	BI Construction: Masonry,concrete, steel, roofing	2010	238,586	11,623	20	11,623		93,296	2
3	BI installation: blinds and shades	2010	10,054	1,005	10	1,005		7,540	3
4	BI construction: vinyl flooring, carpeting	2010	60,995	6,100	10	6,100		45,746	4
5	BI construction: general conditions	2010	330,889	16,120	20	16,120		129,386	5
6	BI installation of cabinetry	2010	1,990	199	10	199		1,493	6
7	BI construction: heating, ventilation, elevator	2010	335,130	16,327	20	16,327		131,044	7
8	BI air testing, monitoring, reporting	2010	3,420	342	10	342		2,565	8
9	BI construction fire protection system	2010	85,492	8,549	10	8,549		64,119	9
10	BI construction: carpentry	2010	341,102	16,618	20	16,618		133,380	10
11	BI connect back up phone, door	2010	4,800		5			4,800	11
12	BI tuckpointing/restoration to chimney stack	2010	3,475		5			3,475	12
13	LI 12" drain.drain tile connect culvert to server	2011	5,070		5			5,070	13
14	LI gable style awing over oxygen storage	2011	1,296		5			1,296	14
15	BI hot water heater	2011	1,753		5			1,753	15
16	BI gutter and sownspout repairs	2011	1,220		5			1,220	16
17	BI repalcement of wall carpeting	2011	2,980		5			2,980	17
18	BI exterior handrail	2012	1,250	125	5	125		1,250	18
19	LI refurbishing of exterior signs	2012	6,100	610	5	610		6,100	19
20	LI asphalt repairs to driveway	2012	825	83	5	83		825	20
21	LI landscaping: installation of catch basin drainage	2012	4,535	454	5	454		4,535	21
22	BI surge suppression system	2013	2,583	517	5	517		2,324	22
23	LI 220 LF of barrier curb	2013	7,902	790	5	790		3,556	23
24	LI 70 SF unilock stack stone split	2013	3,780	756	5	756		3,402	24
25	BI rubber floor replacement	2014	624	125	5	125		437	25
26	BI HM replacement door set	2014	2,883	577	5	577		2,018	26
27	BI installation of bi-fold door	2015	1,925	385	5	385		963	27
28	LI refurbish/revise outdoor sign	2015	2,467	493	5	493		1,234	28
29	LI sidewalk/dumpster pad /ADA ramps/concrete	2015	12,200	1,220	10	1,220		3,050	29
30	LI concrete walk to connect tp park distrcit	2015	1,050	105	10	105		263	30
31	LI asphalt driveway renovation	2015	60,950	6,095	10	6,095		15,238	31
32	LI sidewalk railings	2015	1,450	145	10	145		363	32
33	BI flooring replacement (pod 1)	2016	8,850	885	10	885		1,328	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,380,360	\$ 153,523		\$ 153,523	\$	\$ 4,868,365	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,380,360	\$ 153,523		\$ 153,523	\$	\$ 4,868,365	1
2	BI Ladder for elevator pit	2016	973	97	10	97		146	2
3	BI repainting of roof	2016	11,925	1,193	10	1,193		1,789	3
4	BI install swer pipe installation/remove & replace hydrant	2016	5,344	1,069	5	1,069		1,603	4
5	LI repair existing concrete retaining wall	2016	2,178	109	20	109		163	5
6	BI Relocate Outlets higher wall	2017	3,900	195	10	195		195	6
7	BI Hand Rail Replacement Exterior	2017	4,250	213	10	213		213	7
8	BI Data Line Install	2017	78	4	10	4		4	8
9	BI Electric Outlet Orientation Room	2017	66	2	20	2		2	9
10	BI Carpeting Orientation Room	2017	288	29	5	29		29	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,409,362	\$ 156,432		\$ 156,432	\$	\$ 4,872,508	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:

07/01/16

Ending:

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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	\$ 329,386	\$ 53,888	\$ 53,888	\$		\$ 203,378	71
72	Current Year Purchases	18,308	1,902	1,902			1,902	72
73	Fully Depreciated Assets	859,229					859,229	73
74								74
75	TOTALS	\$ 1,206,923	\$ 55,790	\$ 55,790	\$		\$ 1,064,509	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				\$	\$	\$	\$		\$	76
77	Patient Transport	2006 Ford El Dorado Bus	2006	48,480					48,480	77
78	Courier	2013 Ford Transit Connect	2013	23,020	4,604	4,604			20,718	78
79	Patient Transport	2009 Ford Mobility van	2009	34,475					34,475	79
80	TOTALS			\$ 105,975	\$ 4,604	\$ 4,604	\$		\$ 103,673	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)	\$ 7,753,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 216,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 216,826	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,040,690	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: 07/01/16

Ending: 06/30/2017

**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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 13,570

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	<b>TOTAL</b>		\$	\$	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.

**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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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): _____		30,033	874,573			170,030	30,033	1,044,603	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$ 874,573		\$	\$ 170,030	30,033	\$ 1,044,603	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 &amp; ID Number Marklund Childrens Home

# 0011288

Report Period Beginning: 07/01/16

Ending:

06/30/2017

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 820,532	\$ 820,532	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 259,000 )	4,139,032	4,139,032	3
4	Supply Inventory (priced at )	83,112	83,112	4
5	Short-Term Investments			5
6	Prepaid Insurance	233,175	233,175	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>client related accounts</u>	713,479	713,479	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,989,330	\$ 5,989,330	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	7,717,987	7,717,987	13
14	Buildings, at Historical Cost	28,953,189	28,953,189	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,969,953	6,969,953	16
17	Accumulated Depreciation (book methods)	(23,063,439)	(23,063,439)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	7,809,634	7,809,634	21
22	Other Long-Term Assets (specify):	7,239,029	7,239,029	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 35,626,353	\$ 35,626,353	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 41,615,683	\$ 41,615,683	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 430,636	\$ 430,636	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	220,680	220,680	29
30	Accrued Salaries Payable	494,790	494,790	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,595	37,595	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>compensation &amp; related payables</u>	(166,944)	(166,944)	36
37	<u>misc. other</u>	1,479,106	1,479,106	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,495,863	\$ 2,495,863	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,610,016	1,610,016	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,610,016	\$ 1,610,016	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,105,879	\$ 4,105,879	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 37,509,804	\$ 37,509,804	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 41,615,683	\$ 41,615,683	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>31,925,244</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>31,925,244</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(513,658)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	2,173,718	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Remaining Consolidated Income</b>	2,959,213	<b>15</b>
<b>16</b>	Other (describe) <b>loss on disposal of building &amp; equipment</b>	16,906	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>4,636,179</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfers out of Restricted Funds into Operations- exp.</b>	948,381	<b>18</b>
<b>19</b>	<b>Transfers out of Restricted Funds into Operations-capital</b>	444,477	<b>19</b>
<b>20</b>	<b>Transfers into Operations from Restricted Funds</b>	(444,477)	<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>948,381</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>37,509,804</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,334,850	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,334,850	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	588	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 588	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,603	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,603	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	132,377	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 132,377	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,469,418	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	308,385	31
32	Health Care	1,647,154	32
33	General Administration	644,589	33
<b>B. Capital Expense</b>			
34	Ownership	238,939	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	144,009	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,983,076	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(513,658)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (513,658)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,334,850	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,334,850	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:

07/01/16

Ending:

06/30/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,778	1,872	\$ 77,875	\$ 41.60	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	18,633	19,614	607,096	30.95	3
4	Licensed Practical Nurses	0	0	0		4
5	CNAs & Orderlies	28,791	30,306	442,765	14.61	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	1,482	1,560	53,258	34.14	7
8	Rehab/Therapy Aides	395	416	5,999	14.42	8
9	Activity Director	395	416	7,800	18.75	9
10	Activity Assistants	1,482	1,560	21,740	13.94	10
11	Social Service Workers	395	416	6,660	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	988	1,040	30,503	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	0	0	0		21
22	Other Administrative	20	21	1,278	60.86	22
23	Office Manager	0	0	0		23
24	Clerical	2,766	2,912	45,282	15.55	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	1,976	2,080	35,069	16.86	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	316	333	4,326	12.99	31
32	Other Health Care(specify)	494	520	6,427	12.36	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	71,471	75,234	\$ 1,549,765 *	\$ 20.60	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	73	\$ 3,650	1	35
36	Medical Director	monthly	27,484	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,631	15	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		4,410	10a	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>	6	510	15	46
47	<u>Vision</u>	visit	473	15	47
48	<u>Dental</u>	vist	925	15	48
49	TOTAL (lines 35 - 48)	79	\$ 39,083		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,181	\$ 102,489	10	50
51	Licensed Practical Nurses	8	182	10	51
52	Certified Nurse Assistants/Aides	1,167	29,037	10	52
53	TOTAL (lines 50 - 52)	3,356	\$ 131,708		53



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association, \$1,197
- (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. \$ 18,740 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. \$ 144,009  
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? n/a
  - 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. yes  
Attach invoices and a summary of services for all architect and appraisal fees

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