

		FOR BHF USE					

LL1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0031740

**Facility Name:** MAR KA NURSING HOME

**Address:** 201 SOUTH 10TH STREET MASCOUTAH 62258  
 Number City Zip Code

**County:** ST CLAIR

**Telephone Number:** 618-566-8000 Fax # ( )

**HFS ID Number:** 0031740

**Date of Initial License for Current Owners:** 12/23/86

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** YVONNE CHUA **Telephone Number:** 636-394-3000

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/05 to 9/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JAMES J GIARDINA</u>	
	(Title) <u>PRESIDENT</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL E BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>PO BOX 1190; SPRINGFIELD, MO 65801</u>	
	(Telephone) <u>417-865-8701</u> Fax # <u>417-865-0682</u>	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAR KA NURSING HOME

# 0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

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	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	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	11,958	9,851	2,764	24,573	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,958	9,851	2,764	24,573	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.58%

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

0 (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)

NONE

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 12/23/86

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 12/23/86 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 ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/06 Fiscal Year: 9/30/06

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	151,053	11,056	6,116	168,225		168,225		168,225		1
2	Food Purchase		101,760		101,760		101,760	(774)	100,986		2
3	Housekeeping	128,328	12,459		140,787		140,787	195	140,982		3
4	Laundry	26,753	17,598		44,351		44,351		44,351		4
5	Heat and Other Utilities			82,354	82,354		82,354		82,354		5
6	Maintenance	29,734	18,343	28,881	76,958		76,958	333	77,291		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>335,868</b>	<b>161,216</b>	<b>117,351</b>	<b>614,435</b>		<b>614,435</b>	<b>(246)</b>	<b>614,189</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	940,908	161,901	2,754	1,105,563		1,105,563	17,411	1,122,974		10
10a	Therapy			183,144	183,144		183,144		183,144		10a
11	Activities	45,543	4,967	4,498	55,008		55,008	(1,755)	53,253		11
12	Social Services	30,172	139	1,581	31,892		31,892		31,892		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*			1,234	1,234		1,234		1,234		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,016,623</b>	<b>167,007</b>	<b>199,211</b>	<b>1,382,841</b>		<b>1,382,841</b>	<b>15,656</b>	<b>1,398,497</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,813			53,813		53,813	10,492	64,305		17
18	Directors Fees										18
19	Professional Services			108,162	108,162		108,162	(84,790)	23,372		19
20	Dues, Fees, Subscriptions & Promotions			28,605	28,605		28,605	(3,820)	24,785		20
21	Clerical & General Office Expenses	38,773	12,393	22,195	73,361		73,361	50,306	123,667		21
22	Employee Benefits & Payroll Taxes			299,739	299,739		299,739	1,225	300,964		22
23	Inservice Training & Education			2,745	2,745		2,745		2,745		23
24	Travel and Seminar			3,444	3,444		3,444	5,345	8,789		24
25	Other Admin. Staff Transportation							315	315		25
26	Insurance-Prop.Liab.Malpractice			51,008	51,008		51,008	51	51,059		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>92,586</b>	<b>12,393</b>	<b>515,898</b>	<b>620,877</b>		<b>620,877</b>	<b>(20,876)</b>	<b>600,001</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,445,077</b>	<b>340,616</b>	<b>832,460</b>	<b>2,618,153</b>		<b>2,618,153</b>	<b>(5,466)</b>	<b>2,612,687</b>		<b>29</b>

\*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 MAR KA NURSING HOME #0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			55,333	55,333		55,333	45,503	100,836			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest			2,167	2,167		2,167	43,596	45,763			32
33	Real Estate Taxes			37,275	37,275		37,275		37,275			33
34	Rent-Facility & Grounds			250,800	250,800		250,800	(240,073)	10,727			34
35	Rent-Equipment & Vehicles			1,181	1,181		1,181	2,453	3,634			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			346,756	346,756		346,756	(148,340)	198,416			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			105	105		105		105			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			41,715	41,715		41,715		41,715			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,445,077	340,616	1,220,931	3,006,624		3,006,624	(153,806)	2,852,818			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 MAR KA NURSING HOME

# 0031740

Report Period Beginning: 10/1/05

Ending: 9/30/06

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,281	30		9
10	Interest and Other Investment Income	(212)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(774)	2		13
14	Non-Care Related Interest	(2,167)	32		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	(2,279)	21		18
19	Entertainment	(727)	24		19
20	Contributions	(1,890)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,285)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(703)	20		28
29	Other-Attach Schedule	(11,463)	1,21,22		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (20,219)		\$	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)	(133,587)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (133,587)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (153,806)		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	X		4,790	10.2
43	Prescription Drugs	X		84,777	10.2
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 89,567	47

BHF USE ONLY						
48		49		50		52

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/05

Ending: 9/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INC - HEALTH INS	\$ (9,707)	22	1
2	MISC INC - ACTIVITIES REIMB	(1,755)	11	2
3	MISC INCOME	(1)	21	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>	(11,463)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/05

Ending:

9/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(774)	0	0	0	0	0	0	0	0	0	0	(774)	2
3	Housekeeping	0	0	195	0	0	0	0	0	0	0	0	195	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	333	0	0	0	0	0	0	0	0	333	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(774)</b>	<b>0</b>	<b>528</b>	<b>0</b>	<b>(246)</b>	<b>8</b>							
	<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	17,411	0	0	0	0	0	0	0	0	0	17,411	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,755)	0	0	0	0	0	0	0	0	0	0	(1,755)	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>	<b>(1,755)</b>	<b>17,411</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>15,656</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	10,492	0	0	0	0	0	0	0	0	0	10,492	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(84,790)	0	0	0	0	0	0	0	0	0	(84,790)	19
20	Fees, Subscriptions & Promotions	(3,988)	0	168	0	0	0	0	0	0	0	0	(3,820)	20
21	Clerical & General Office Expenses	(4,170)	54,476	0	0	0	0	0	0	0	0	0	50,306	21
22	Employee Benefits & Payroll Taxes	(9,707)	10,932	0	0	0	0	0	0	0	0	0	1,225	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(727)	6,072	0	0	0	0	0	0	0	0	0	5,345	24
25	Other Admin. Staff Transportation	0	0	315	0	0	0	0	0	0	0	0	315	25
26	Insurance-Prop.Liab.Malpractice	0	0	51	0	0	0	0	0	0	0	0	51	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(18,592)</b>	<b>(2,818)</b>	<b>534</b>	<b>0</b>	<b>(20,876)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(21,121)</b>	<b>14,593</b>	<b>1,062</b>	<b>0</b>	<b>(5,466)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/05

Ending:

9/30/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	3,281	42,222	0	0	0	0	0	0	0	0	0	45,503	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(2,379)	45,975	0	0	0	0	0	0	0	0	0	43,596	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(240,073)	0	0	0	0	0	0	0	0	0	(240,073)	34
35	Rent-Equipment & Vehicles	0	2,453	0	0	0	0	0	0	0	0	0	2,453	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>902</b>	<b>(149,242)</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>(148,340)</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 (sum of lines 29, 37 &amp; 44)</b>	<b>(20,219)</b>	<b>(134,649)</b>	<b>1,062</b>	<b>0</b>	<b>(153,806)</b>	<b>45</b>							

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/05

Ending:

9/30/06

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	MONMOUTH NURSING HOME	MONMOUTH	CARE CTRS, INC	BALLWIN, MO	HOME OFFICE
				RISA	JEFFERSON CITY, MO	W/C INS
				RISA	JEFFERSON CITY, MO	LIAB INS

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 BUILDING RENT	\$ 250,800	JAMES J GIARDINA	100.00%	\$	\$ (250,800) 1
2	V	32 INTEREST EXPENSE		JAMES J GIARDINA	100.00%	45,975	45,975 2
3	V	30 DEPRECIATION		JAMES J GIARDINA	100.00%	42,222	42,222 3
4	V	31 AMORTIZATION		JAMES J GIARDINA	100.00%	181	181 4
5	V	19 HOME OFFICE	88,200	COMMUNITY CARE CENTERS, INC	COMMON		(88,200) 5
6	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	10,727	10,727 6
7	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	2,453	2,453 7
8	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	17,411	17,411 8
9	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	10,492	10,492 9
10	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	54,476	54,476 10
11	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	10,932	10,932 11
12	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	3,410	3,410 12
13	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	6,072	6,072 13
14	Total		\$ 339,000			\$ 204,351	\$ * (134,649) 14

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)
		Item			Name of Related Organization					
15	V	25	HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC	COMMON	\$ 315	\$ 315	15	
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	333	333	16	
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	168	168	17	
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	51	51	18	
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	195	195	19	
20	V	22	WORKERS COMP INS	106,774	RISA	25.00%	106,774		20	
21	V	26	LIABILITY INS	44,502	RISA	25.00%	44,502		21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 151,276			\$ 152,338	\$ *	1,062	39

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

## 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	JAMES J GIARDINA	PRESIDENT	GENERAL DIR.	100.00	NONE	3	6.00	SALARY	\$ 6,456	17.7	1
2	BETTY HUGHES	SECRETARY		0.00	NONE	3	7.14	SALARY	4,036	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,492		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 MAR KA NURSING HOME

# 0031740

Report Period Beginning: 10/1/05

Ending: 9/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization COMMUNITY CARE CENTERS, INC  
 Street Address 312 SOLLEY DRIVE - REAR  
 City / State / Zip Code BALLWIN, MO 63021  
 Phone Number ( 636-394-3000  
 Fax Number ( 636-394-7713

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	19	HOME OFFICE	DIRECT COST		\$	\$		\$	1
2		WEST COUNTY CARE CENTER					5,339,306	204,067	2
3		ST GENEVIEVE CARE CTR					2,307,399	81,166	3
4		CCC OF LEMAY					2,208,017	87,857	4
5		SALEM CARE CENTER					1,747,427	62,309	5
6		MONMOUTH NH					2,230,753	74,900	6
7		MAR-KA NH					2,918,424	117,035	7
8		WEST MAIN NH					2,546,190	84,943	8
9		CCC OF SENECA					2,569,979	88,419	9
10		MT VERNON PLACE CARE					2,015,154	74,562	10
11		COUNTRY VIEW NH					2,636,073	118,530	11
12		MERAMEC NH					2,768,251	93,570	12
13		SEVILLE CARE CENTER					533,663	17,467	13
14		SALEM RES CARE					44,419	1,454	14
15		BOSS RES CARE					614,100	20,100	15
16		CARL JUNCTION RES CARE					504,072	16,499	16
17		MT VERNON RES CARE					459,406	15,037	17
18		SENECA HOME PLACE					518,315	16,965	18
19		HUDSON HOUSE					2,667,783	135,970	19
20		MAPLE GROVE LODGE					4,223,776	140,398	20
21		CCC OF AURORA					2,498,209	85,523	21
22		BARRY COMMUNITY CARE					383,431	12,550	22
23		LICKING RES CARE					421,218	19,164	23
24		COMMUNITY IN HOME					790,625	25,878	24
25	TOTALS				\$	\$		\$ 1,594,363	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		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							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6	<b>DUE RELATED PARTY</b>	X									2,167	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>							\$	\$			\$	2,167	9			
	<b>B. Non-Facility Related*</b>																
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>							\$	\$			\$		14			
15	<b>TOTALS (line 9+line14)</b>							\$	\$			\$	2,167	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME MAR KA NURSING HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0031740

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: (   )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>10-31.01-114-007</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ <u>35,804.00</u>	\$ <u> </u>
2. <u> </u>	<u>BLK/RG-6W PT LOT 12C</u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u>AS IN BK 2659-1974</u>	\$ <u> </u>	\$ <u> </u>
4. <u>10-31.0-113-009</u>	<u>LOT/SEC-18 BK 2659-1974</u>	\$ <u>188.00</u>	\$ <u> </u>
5. <u>10-31.0-114-009</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ <u>144.00</u>	\$ <u> </u>
6. <u> </u>	<u>BLK/RG-6W BK 2659-1974</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>
<b>TOTALS</b>		\$ <u>36,136.00</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 X NO

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**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 MAR KA NURSING HOME

# 0031740 Report Period Beginning:

10/1/05 Ending:

9/30/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,425 B. General Construction Type: Exterior BRICK Frame STEEL REINFORCE Number of Stories 1

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).

NONE

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>48,000</u>	<u>Dec-86</u>	<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>48,000</b>		<b>\$ 75,000</b>	<b>3</b>

Facility Name & ID Number **MAR KA NURSING HOME**# **0031740**

Report Period Beginning:

**10/1/05**

Ending:

**9/30/06****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1986	1970	\$ 950,000	\$	22.5	\$ 42,222	\$ 42,222	\$ 805,574	4
5			1986		14,621		10			14,621	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		ROOF REPAIR		1989	4,686		10			4,686	9
10		PATIO AND RAMP		1991	3,252		12			3,252	10
11		PATIO ROOF		1991	2,890		10			2,890	11
12		FLAT ROOF		1991	14,000		10			14,000	12
13		ROOF (NORTH WING)		1992	10,000		10			10,000	13
14		ROOF REPAIR		1990	7,055		10			7,055	14
15		SIDING REPAIR		1990	4,276		10			4,276	15
16		SPRINKLER SYSTEM		1993	2,168		25			2,168	16
17		BULLOCK GARAGES		1993	7,176		15			7,176	17
18		5 TON REFRIGERATION UNIT		1995	3,814		10			3,814	18
19		ROOF REPAIR		1995	18,785		10			18,785	19
20		LANDSCAPING - PATIO		1995	3,342		10			3,342	20
21		ROOFING REPAIR		1997	12,732		10			12,732	21
22		AIR CONDITIONING		1997	3,760		10			3,760	22
23		PHONE SYSTEM		1998	3,780		10			3,780	23
24		ELECTRICAL WORK		1999	3,613		20			3,613	24
25		COUNTERTOPS		1999	2,127		20			2,127	25
26		LENNOX 7.5 ROOFTOP UNIT		2000	5,733		10			5,733	26
27		ROOF ON EAST ASH WING		2000	6,400		10			6,400	27
28		MECHANICAL ROOM IMPR		2001	23,797		15			23,797	28
29		FIRE DAMPERS IN DUCT WORK		2001	1,900		15			1,900	29
30		FIRE DAMPERS IN DUCT WORK		2001	3,059		15			3,059	30
31		EXTERIOR KITCHEN DOORS		2002	1,567		20			1,567	31
32		RE-PLATE DOORS		2002	9,398		10			9,398	32
33		GAS WATER HEATER		2002	6,235		10			6,235	33
34		MIXING VALVE HOT WATER TAN		2002	1,143		10			1,143	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **MAR KA NURSING HOME**

# **0031740**

Report Period Beginning:

10/1/05

Ending:

9/30/06

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	SEWAGE MOTOR EJECTOR PU	2003	\$ 1,567	\$ 152	Lease Life	\$ 152	\$	\$ 1,567	37
38	2 REMINGTON 9000BTU A/C'S	2003	1,135	110	Lease Life	110		1,135	38
39	2 REMINGTON 9000BTU A/C'S	2003	1,135	110	Lease Life	110		1,135	39
40	1 REMINGTON 9000BTU A/C'S	2003	566	57	Lease Life	57		566	40
41	5TON ROOFTOP A/C UNIT	2003	5,471	529	Lease Life	529		5,471	41
42	KATOLIGHT GENERATOR	2004	20,641	2,949	Lease Life	2,949		20,641	42
43	RE-PAVE PARKING LOT-GRAVEL	2004	5,470	966	Lease Life	966		5,470	43
44	CARPET FOR OFFICES	2005	1,036	283	Lease Life	283		1,036	44
45	UPGRADE WANDERGUARD SYST	2005	4,997	2,498	Lease Life	2,498		4,997	45
46	ROOF OAK HALL, KITCHEN	2005	27,333	27,323	Lease Life	27,323		27,333	46
47	RIGHT SIDEWALK-CONCRETE	2005	6,298	6,298	Lease Life	6,298		6,298	47
48	HEAT EXCHANGER & THERMOSTAT FOR FURNACE	2006	2,962	762	Lease Life	762		762	48
49	GUTTERING & DOWNSPOUTS	2006	8,000	296	Lease Life	296		296	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60	PRIOR YEAR AUDIT ADJUST TO CORRECT DEPR			(3,281)			3,281		60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,217,920	\$ 39,052		\$ 84,555	\$ 45,503	\$ 1,063,587	70

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/05 Ending: 9/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 170,860	\$ 14,945	\$ 14,945	\$	VARIOUS	\$ 112,538	71
72	Current Year Purchases	14,240	1,336	1,336		VARIOUS	1,336	72
73	Fully Depreciated Assets							73
74	DISPOSALS	(8,881)					(5,699)	74
75	TOTALS	\$ 176,219	\$ 16,281	\$ 16,281	\$		\$ 108,175	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NONE			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,469,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,333	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,836	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,503	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,171,762	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	RETAINER FEE	\$ 5,000	92
93			93
94			94
95		\$ 5,000	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: RELATED PARTY COSTS

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 1,181 Description: Truck Rental - \$884; Storage - \$80; Humidifier/resident - \$217

(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		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)	
<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	10a.3	hrs	\$	881	\$ 67,632	\$	881	\$ 67,632	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		149	13,512		149	13,512	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,251	102,000		1,251	102,000	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	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	2,281	\$ 183,144	\$	2,281	\$ 183,144	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 MAR KA NURSING HOME# 0031740Report Period Beginning: 10/1/05

Ending:

9/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 9/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,596	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>27,100</u> )	496,869		3
4	Supply Inventory (priced at )	1,650		4
5	Short-Term Investments	2,472		5
6	Prepaid Insurance	41,166		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due To/From Rel Parties</u>	(1,003,025)		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ (450,272)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	241,960		15
16	Equipment, at Historical Cost	176,219		16
17	Accumulated Depreciation (book methods)	(340,232)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 77,947	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ (372,325)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 107,617	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,938		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,102		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,886		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,180		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>Due To/From Rel Parties</u>	113,404		36
37	<u>Due To Medicare</u>	5,653		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 360,780	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 360,780	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (733,105)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ (372,325)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(517,517)</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>(517,517)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(141,411)	<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		<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>PRIOR YEAR ADJS - DEPR EXP</b>	(74,177)	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(215,588)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(733,105)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning: 10/1/05

Ending: 9/30/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,895,150	1
2	Discounts and Allowances for all Levels	(10,691,025)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,204,125	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	436,809	6
7	Oxygen	174,074	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 610,883	8
<b>C. Other Operating Revenue</b>			
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	915	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 915	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,000	24
25	Interest and Other Investment Income***	212	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,212	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS INCOME</b>	15,415	28
28a	<b>Rel Party Forgiveness of Debt</b>	31,663	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 47,078	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,865,213	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	614,435	31
32	Health Care	1,382,841	32
33	General Administration	620,877	33
<b>B. Capital Expense</b>			
34	Ownership	346,756	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	105	35
36	Provider Participation Fee	41,610	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,006,624	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(141,411)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (141,411)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN  
PREPARED ON  
CASH BASIS

\*\*\* 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 MAR KA NURSING HOME

# 0031740

Report Period Beginning: 10/1/05

Ending:

9/30/06

**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	1,792	1,912	\$ 37,458	\$ 19.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,891	4,027	73,185	18.17	3
4	Licensed Practical Nurses	22,040	23,228	359,197	15.46	4
5	CNAs & Orderlies	45,662	47,913	455,825	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,831	1,967	21,607	10.98	9
10	Activity Assistants	1,945	2,143	23,936	11.17	10
11	Social Service Workers	2,775	2,959	30,172	10.20	11
12	Dietician					12
13	Food Service Supervisor	1,763	2,013	21,067	10.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,032	7,393	62,191	8.41	15
16	Dishwashers	8,211	8,576	67,795	7.91	16
17	Maintenance Workers	2,469	2,641	29,734	11.26	17
18	Housekeepers	13,479	14,441	128,328	8.89	18
19	Laundry	3,482	3,715	26,753	7.20	19
20	Administrator	1,928	2,080	53,813	25.87	20
21	Assistant Administrator					21
22	Other Administrative	2,605	2,720	38,773	14.25	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,512	1,628	15,243	9.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,417	129,356	\$ 1,445,077 *	\$ 11.17	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	173	\$ 6,067	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	47	1,654	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	1,100	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,581	11.3	44
45	Social Service Consultant	31	1,581	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	374	\$ 17,983		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number **MAR KA NURSING HOME**

# **0031740**

Report Period Beginning: **10/1/05**

Ending: **9/30/06**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
AIMEE COUCH	ADMINISTRATOR	0	\$ 53,813	Workers' Compensation Insurance	\$ 106,774	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	13,833		
				FICA Taxes	148,808	Health Care Worker Background Check			
				Employee Health Insurance	37,096	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	30 480		
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	3,141		
				OTHER EMPLOYEE BENEFITS	6,026	TAXES & LICENSES	7,163		
				401K CONTRIBUTIONS	1,035	ADVERTISING OTHER	3,988		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 53,813	HOME OFFICE ALLOCATION	10,932	HOME OFFICE ALLOCATION	168		
(List each licensed administrator separately.)				SCH VI OFFSET OF HEALTH INS	(9,707)	Less: Public Relations Expense	( )		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
NONE				NONE			Out-of-State Travel	\$	
							In-State Travel	2,717	
							MEALS	726	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$ 300,964	Seminar Expense	
(Attach a copy of any management service agreement)								HOME OFFICE ALLOCATION	6,072
C. Professional Services									
Vendor/Payee	Type		Amount						
COMMUNITY CARE CENTERS, INC	MGMT FEES		88,200						
BKD, LLP	ACCOUNTING		13,065						
THE SCHINDLER LAW FIRM	LEGAL		196						
ARMSTRONG TEASDALE	LEGAL		463						
ELVIDGE KELLEY	LEGAL		5,297						
HUSCH & EPPENBERGER	LEGAL		36						
MICHIGAN PEER REVIEW	LEGAL		905						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 108,162				\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,785
(If total legal fees exceed \$5,000, attach copy of invoices.)								Entertainment Expense	(726)
								TOTAL	\$ 8,789

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number MAR KA NURSING HOME

**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. IL HCA \$4,172
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (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? 3-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 922 Line 10.2
- (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. \$ 41,610  
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. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? YES  
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? 30%
- 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? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: BKD, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. TO BE SENT WHEN COMPLETED
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? \_\_\_\_\_  
Attach invoices and a summary of services for all architect and appraisal fees.