

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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
IRS Exemption Code _____	<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 10/01/06 to 9/30/07 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JAMES J GIARDINA</u>	
	(Title) <u>PRESIDENT</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. 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: 10/01/06 Ending: 9/30/07

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	12,841	9,015	2,060	23,916	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,841	9,015	2,060	23,916	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.21%

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 76 and days of care provided 1,896

Medicare Intermediary NGS (ADMINISTAR FEDERAL)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/07 Fiscal Year: 9/30/07

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/06 Ending: 9/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	156,973	12,796	4,832	174,601		174,601	(45)	174,556		1
2	Food Purchase		110,468		110,468		110,468	(365)	110,103		2
3	Housekeeping	118,072	12,475		130,547		130,547	182	130,729		3
4	Laundry	31,566	17,722		49,288		49,288		49,288		4
5	Heat and Other Utilities			83,927	83,927		83,927		83,927		5
6	Maintenance	27,016	35,459	24,252	86,727		86,727	370	87,097		6
7	Other (specify):*										7
8	TOTAL General Services	333,627	188,920	113,011	635,558		635,558	142	635,700		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	984,987	200,201	5,788	1,190,976		1,190,976	22,620	1,213,596		10
10a	Therapy		363	176,298	176,661		176,661		176,661		10a
11	Activities	47,596	6,325	3,543	57,464		57,464		57,464		11
12	Social Services	30,663	456	1,812	32,931		32,931		32,931		12
13	CNA Training			966	966		966		966		13
14	Program Transportation			240	240		240		240		14
15	Other (specify):*			90	90		90		90		15
16	TOTAL Health Care and Programs	1,063,246	207,345	194,737	1,465,328		1,465,328	22,620	1,487,948		16
	C. General Administration										
17	Administrative	61,367			61,367		61,367	10,024	71,391		17
18	Directors Fees										18
19	Professional Services			100,285	100,285		100,285	(85,844)	14,441		19
20	Dues, Fees, Subscriptions & Promotions			29,903	29,903		29,903	(5,131)	24,772		20
21	Clerical & General Office Expenses	28,837	13,389	29,407	71,633		71,633	42,859	114,492		21
22	Employee Benefits & Payroll Taxes			286,822	286,822		286,822	10,716	297,538		22
23	Inservice Training & Education			2,008	2,008		2,008		2,008		23
24	Travel and Seminar			2,146	2,146		2,146	3,875	6,021		24
25	Other Admin. Staff Transportation							557	557		25
26	Insurance-Prop.Liab.Malpractice			50,800	50,800		50,800	48	50,848		26
27	Other (specify):*										27
28	TOTAL General Administration	90,204	13,389	501,371	604,964		604,964	(22,896)	582,068		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,487,077	409,654	809,119	2,705,850		2,705,850	(134)	2,705,716		29

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

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

Facility Name & ID Number MAR KA NURSING HOME #0031740 Report Period Beginning: 10/01/06 Ending: 9/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			30,325	30,325	30,325	42,222	72,547			30
31	Amortization of Pre-Op. & Org.						181	181			31
32	Interest			781	781	781	40,959	41,740			32
33	Real Estate Taxes			40,832	40,832	40,832		40,832			33
34	Rent-Facility & Grounds			250,800	250,800	250,800	(240,259)	10,541			34
35	Rent-Equipment & Vehicles			1,832	1,832	1,832	3,025	4,857			35
36	Other (specify):*										36
37	TOTAL Ownership			324,570	324,570	324,570	(153,872)	170,698			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			173	173	173		173			40
41	Coffee and Gift Shops			41,610	41,610	41,610		41,610			41
42	Provider Participation Fee										42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			41,783	41,783	41,783		41,783			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,487,077	409,654	1,175,472	3,072,203	3,072,203	(154,006)	2,918,197			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: 10/01/06

Ending: 9/30/07

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	(45)	1		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	(958)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(365)	2		13
14	Non-Care Related Interest	(781)	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	(11,213)	21		18
19	Entertainment	(364)	24		19
20	Contributions	(50)	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	(3,507)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(384)	20		28
29	Other-Attach Schedule	(5,708)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,375)		\$	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	(130,631)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (130,631)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (154,006)		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		35,400	10.2	42
43	Prescription Drugs	X		97,647	10.2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 133,047		47

BHF USE ONLY						
48		49		50		51
						52

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/01/06

Ending: 9/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	\$ (1,346)	20	1
2	MISC INC - HEALTH INS	(2,210)	22	2
3	MISC INCOME	(2,152)	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	Total	(5,708)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/06

Ending:

9/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(45)	0	0	0	0	0	0	0	0	0	0	(45)	1
2	Food Purchase	(365)	0	0	0	0	0	0	0	0	0	0	(365)	2
3	Housekeeping	0	0	182	0	0	0	0	0	0	0	0	182	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	370	0	0	0	0	0	0	0	0	370	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(410)	0	552	0	142	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	22,620	0	0	0	0	0	0	0	0	0	22,620	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	22,620	0	0	0	0	0	0	0	0	0	22,620	16
	C. General Administration													
17	Administrative	0	10,024	0	0	0	0	0	0	0	0	0	10,024	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(85,844)	0	0	0	0	0	0	0	0	0	(85,844)	19
20	Fees, Subscriptions & Promotions	(5,237)	0	106	0	0	0	0	0	0	0	0	(5,131)	20
21	Clerical & General Office Expenses	(13,415)	56,274	0	0	0	0	0	0	0	0	0	42,859	21
22	Employee Benefits & Payroll Taxes	(2,210)	12,926	0	0	0	0	0	0	0	0	0	10,716	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(364)	4,239	0	0	0	0	0	0	0	0	0	3,875	24
25	Other Admin. Staff Transportation	0	0	557	0	0	0	0	0	0	0	0	557	25
26	Insurance-Prop.Liab.Malpractice	0	0	48	0	0	0	0	0	0	0	0	48	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,226)	(2,381)	711	0	(22,896)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,636)	20,239	1,263	0	(134)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/06 Ending:

9/30/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	42,222	0	0	0	0	0	0	0	0	0	42,222	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(1,739)	42,698	0	0	0	0	0	0	0	0	0	40,959	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(240,259)	0	0	0	0	0	0	0	0	0	(240,259)	34
35	Rent-Equipment & Vehicles	0	3,025	0	0	0	0	0	0	0	0	0	3,025	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,739)	(152,133)	0	0	0	0	0	0	0	0	0	(153,872)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,375)	(131,894)	1,263	0	(154,006)	45							

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/01/06

Ending:

9/30/07

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
<u>JAMES J GIARDINA</u>	<u>100</u>	<u>MONMOUTH NURSING HOME</u>	<u>MONMOUTH</u>	<u>COMMUNITY CARE CTRS, INC</u>	<u>BALLWIN, MO</u>	<u>HOME OFFICE</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>W/C INS</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>LIAB INS</u>

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>34 BUILDING RENT</u>	\$ <u>250,800</u>	<u>JAMES J GIARDINA</u>	<u>100.00%</u>	\$	\$ <u>(250,800)</u>	1
2	V	<u>32 INTEREST EXPENSE</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>42,698</u>	<u>42,698</u>	2
3	V	<u>30 DEPRECIATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>42,222</u>	<u>42,222</u>	3
4	V	<u>31 AMORTIZATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>181</u>	<u>181</u>	4
5	V	<u>19 HOME OFFICE</u>	<u>88,200</u>	<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>		<u>(88,200)</u>	5
6	V	<u>34 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>10,541</u>	<u>10,541</u>	6
7	V	<u>35 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>3,025</u>	<u>3,025</u>	7
8	V	<u>10 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>22,620</u>	<u>22,620</u>	8
9	V	<u>17 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>10,024</u>	<u>10,024</u>	9
10	V	<u>21 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>56,274</u>	<u>56,274</u>	10
11	V	<u>22 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>12,926</u>	<u>12,926</u>	11
12	V	<u>19 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>2,356</u>	<u>2,356</u>	12
13	V	<u>24 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>COMMON</u>	<u>4,239</u>	<u>4,239</u>	13
14	Total		\$ <u>339,000</u>			\$ <u>207,106</u>	\$ * <u>(131,894)</u>	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: 10/01/06 Ending: 9/30/07

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		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	4 Amount	Name of Related Organization						
15	V	25	HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC.	COMMON	\$ 557	\$ 557	15	
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	370	370	16	
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	106	106	17	
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	48	48	18	
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	182	182	19	
20	V	22	WORKERS COMP INS	77,433	RISA	25.00%	77,433		20	
21	V	26	LIABILITY INS	45,600	RISA	25.00%	45,600		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			\$ 123,033			\$ 124,296	\$ *	1,263	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: 10/01/06 Ending: 9/30/07

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	GEN DIRECTOR	100.00	NONE	3	6.00	SALARY	\$ 6,027	17.7	1
2	BETTY HUGHES	SECRETARY		0.00	NONE	2	5.00	SALARY	3,997	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	\$ 10,024		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: 10/01/06

Ending: 9/30/07

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			\$	\$		\$	1
2		WEST COUNTY CARE CENTER					5,307,567	199,300	2
3		ST GENEVIEVE CARE CTR					2,545,616	85,525	3
4		CCC OF LEMAY					2,462,676	92,005	4
5		SALEM CARE CENTER					1,293,013	43,955	5
6		MONMOUTH NH					2,239,866	76,110	6
7		MAR-KA NH					2,984,003	123,268	7
8		CCC OF SENECA					2,816,361	98,724	8
9		MT VERNON PLACE CARE					2,686,003	94,127	9
10		COUNTRY VIEW NH					2,150,970	119,977	10
11		MERAMEC NH					2,640,508	106,172	11
12		SEVILLE CARE CENTER					2,871,893	95,358	12
13		SALEM RES CARE					576,113	18,714	13
14		CARL JUNCTION RES CARE					655,589	21,297	14
15		MT VERNON RES CARE					516,335	16,772	15
16		SENECA HOME PLACE					510,546	16,586	16
17		HUDSON HOUSE					530,685	17,240	17
18		MAPLE GROVE LODGE					2,856,567	115,680	18
19		CCC OF AURORA					4,674,522	152,364	19
20		BARRY COMMUNITY CARE					2,709,134	90,071	20
21		LICKING RESIDENTIAL CTR					402,131	13,062	21
22		CCC OF GAINESVILLE					2,415,594	83,792	22
23		AL OF SILVER CREEK					342,585	11,646	23
24		COMMUNITY IN HOME					846,367	27,647	24
25	TOTALS				\$	\$		\$ 1,719,392	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	DUE RELATED PARTY	X								781	6									
7										7										
8										8										
9	TOTAL Facility Related									781	9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									781	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.)

Facility Name & ID Number MAR KA NURSING HOME

0031740 Report Period Beginning:

10/01/06 Ending:

9/30/07

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).

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	TOTALS	48,000		\$ 75,000	3

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

Report Period Beginning:

10/01/06

Ending:

9/30/07**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	\$ 847,796	4
5			1986		14,621		10			14,621	5
6											6
7											7
8											8
		Improvement Type**									
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											33
34											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:

10/01/06

Ending:

9/30/07

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	\$	Lease Life	\$	\$	\$ 1,567	37
38	2 REMINGTON 9000BTU A/C'S	2003	1,135		Lease Life			1,135	38
39	2 REMINGTON 9000BTU A/C'S	2003	1,135		Lease Life			1,135	39
40	1 REMINGTON 9000BTU A/C'S	2003	566		Lease Life			566	40
41	5TON ROOFTOP A/C UNIT	2003	5,471		Lease Life			5,471	41
42	KATOLIGHT GENERATOR	2004	20,641		Lease Life			20,641	42
43	RE-PAVE PARKING LOT-GRAVEL	2004	5,470		Lease Life			5,470	43
44	CARPET FOR OFFICES	2005	1,036		Lease Life			1,036	44
45	UPGRADE WANDERGUARD SYST	2005	4,997		Lease Life			4,997	45
46	ROOF OAK HALL, KITCHEN	2005	27,333		Lease Life			27,333	46
47	RIGHT SIDEWALK-CONCRETE	2005	6,298		Lease Life			6,298	47
48	HEAT EXCHANGER & THERMOSTAT FOR FURNACE	2006	2,962		Lease Life	1,015	1,015	1,777	48
49	GUTTERING & DOWNSPOUTS	2006	8,000		Lease Life	3,556	3,556	3,852	49
50	81 GAL WATER HEATER	2007	4,030		Lease Life	1,466	1,466	1,466	50
51	ROOF 300 WING	2007	17,000		Lease Life	4,474	4,474	4,474	51
52	CHANDELIER	2007	2,075		Lease Life	259	259	259	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									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)		\$ 1,233,647	\$		\$ 52,992	\$ 52,992	\$ 1,109,204	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: 10/01/06 Ending: 9/30/07

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	\$ 176,219	\$ 14,782	\$ 14,782	\$	VARIOUS	\$ 102,963	71
72	Current Year Purchases	19,714	1,244	1,244		VARIOUS	1,244	72
73	Fully Depreciated Assets							73
74	DISPOSALS	(11,761)	3,529	3,529		VARIOUS	11,761	74
75	TOTALS	\$ 184,172	\$ 19,555	\$ 19,555	\$		\$ 115,968	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				\$	\$	\$	\$		\$	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)	\$ 1,492,819	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,547	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 52,992	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,225,172	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 1,832 Description: Rental: Truck \$300; Lift \$290; Trencher \$70; Storage \$760; Med equip \$214; Oxygen \$198

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/01/06 Ending: 9/30/07

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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>85</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>42</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$ 966	\$	\$ 966
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	\$	\$ 966	\$	\$ 966
10	SUM OF line 9, col. 1 and 2 (e)	\$	966		

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	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (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.

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/01/06

Ending:

9/30/07

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	\$	957	\$ 64,437	\$	957	\$ 64,437	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		237	16,612	23	237	16,635	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,421	95,249	340	1,421	95,589	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	2,615	\$ 176,298	\$ 363	2,615	\$ 176,661	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: 10/01/06

Ending:

9/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,552	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>27,100</u>)	510,950		3
4	Supply Inventory (priced at)	1,650		4
5	Short-Term Investments	4,845		5
6	Prepaid Insurance	19,075		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due To/From Rel Parties</u>	(695,924)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (143,852)	\$	10
	B. Long-Term Assets			
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	257,687		15
16	Equipment, at Historical Cost	184,172		16
17	Accumulated Depreciation (book methods)	(351,417)		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): <u>Employee Advances</u>	(43)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 90,399	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (53,453)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 587,345	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,852		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,683		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,937		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,160		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due To/From Related Parties</u>	102,600		36
37	<u>Due To Medicare</u>	10,204		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 844,781	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 844,781	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (898,234)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (53,453)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (733,105)	1
2	Restatements (describe):		2
3			3
4	ROUNDING	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (733,103)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(165,131)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (165,131)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (898,234)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MAR KA NURSING HOME# 0031740Report Period Beginning: 10/01/06Ending: 9/30/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,156,550	1
2	Discounts and Allowances for all Levels	(10,911,415)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,245,135	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	420,186	6
7	Oxygen	236,243	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 656,429	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	45	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	2,731	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,776	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	958	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 958	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	A/P DISC; RES SALES; MISC INCOME	1,774	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,774	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,907,072	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	635,558	31
32	Health Care	1,465,328	32
33	General Administration	604,964	33
B. Capital Expense			
34	Ownership	324,570	34
C. Ancillary Expense			
35	Special Cost Centers	173	35
36	Provider Participation Fee	41,610	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,072,203	40
41	Income before Income Taxes (line 30 minus line 40)**	(165,131)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (165,131)	43

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

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

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

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

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

0031740

Report Period Beginning: **10/01/06**

Ending:

9/30/07

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	1,756	1,788	\$ 44,202	\$ 24.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,601	3,745	69,677	18.61	3
4	Licensed Practical Nurses	22,959	24,432	382,975	15.68	4
5	CNAs & Orderlies	48,480	50,860	479,261	9.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,934	2,071	23,785	11.48	9
10	Activity Assistants	1,870	2,124	23,811	11.21	10
11	Social Service Workers	2,692	3,137	30,663	9.77	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,145	23,341	10.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,082	5,273	48,882	9.27	15
16	Dishwashers	10,396	10,735	84,750	7.89	16
17	Maintenance Workers	1,774	1,958	27,016	13.80	17
18	Housekeepers	11,561	12,693	118,072	9.30	18
19	Laundry	3,914	4,239	31,566	7.45	19
20	Administrator	1,979	2,231	61,367	27.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,184	2,264	28,837	12.74	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	1,010	1,044	8,872	8.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,225	130,739	\$ 1,487,077 *	\$ 11.37	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	130	\$ 4,477	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	43	1,688	10.3	37
38	Nurse Consultant		2,900	10.3	38
39	Pharmacist Consultant	48	1,200	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	34	1,812	11.3	44
45	Social Service Consultant	34	1,812	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	337	\$ 19,889		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

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 \$4,546
- (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. \$ 497 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? 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? 39%
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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.