

Facility Name & ID Number MAR KA NURSING HOME

0031740 Report Period Beginning: 10/1/09 Ending: 9/30/10

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	8,219	7,937	2,653	18,809	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,219	7,937	2,653	18,809	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.80%

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 2,017

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/10 Fiscal Year: 9/30/10

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

Facility Name & ID Number **MAR KA NURSING HOME** # **0031740** Report Period Beginning: **10/1/09** Ending: **9/30/10**

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	166,783	10,801	3,095	180,679		180,679		180,679		1
2	Food Purchase		95,479		95,479		95,479	(374)	95,105		2
3	Housekeeping	93,636	12,184		105,820		105,820	151	105,971		3
4	Laundry	50,499	12,822		63,321		63,321		63,321		4
5	Heat and Other Utilities			87,379	87,379		87,379		87,379		5
6	Maintenance	31,639	20,003	30,374	82,016		82,016	54	82,070		6
7	Other (specify):*										7
8	TOTAL General Services	342,557	151,289	120,848	614,694		614,694	(169)	614,525		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	840,326	248,220	6,591	1,095,137		1,095,137	19,394	1,114,531		10
10a	Therapy		38	162,553	162,591		162,591		162,591		10a
11	Activities	28,941	7,022	2,367	38,330		38,330		38,330		11
12	Social Services	43,283		463	43,746		43,746		43,746		12
13	CNA Training										13
14	Program Transportation			4,656	4,656		4,656	(575)	4,081		14
15	Other (specify):* Ambulance			342	342		342		342		15
16	TOTAL Health Care and Programs	912,550	255,280	182,972	1,350,802		1,350,802	18,819	1,369,621		16
	C. General Administration										
17	Administrative	60,322			60,322		60,322	7,249	67,571		17
18	Directors Fees										18
19	Professional Services			113,795	113,795		113,795	(94,420)	19,375		19
20	Dues, Fees, Subscriptions & Promotions			43,575	43,575		43,575	(15,042)	28,533		20
21	Clerical & General Office Expenses	27,950	9,890	30,407	68,247		68,247	51,408	119,655		21
22	Employee Benefits & Payroll Taxes			201,095	201,095		201,095	12,854	213,949		22
23	Inservice Training & Education			1,840	1,840		1,840		1,840		23
24	Travel and Seminar			7,865	7,865		7,865	5,360	13,225		24
25	Other Admin. Staff Transportation							413	413		25
26	Insurance-Prop.Liab.Malpractice			35,925	35,925		35,925	39	35,964		26
27	Other (specify):*										27
28	TOTAL General Administration	88,272	9,890	434,502	532,664		532,664	(32,139)	500,525		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,343,379	416,459	738,322	2,498,160		2,498,160	(13,489)	2,484,671		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,926	27,926		27,926	17,760	45,686			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest			1,154	1,154		1,154	33,187	34,341			32
33	Real Estate Taxes			50,640	50,640		50,640		50,640			33
34	Rent-Facility & Grounds			250,800	250,800		250,800	(242,950)	7,850			34
35	Rent-Equipment & Vehicles			1,733	1,733		1,733	1,933	3,666			35
36	Other (specify):*											36
37	TOTAL Ownership			332,253	332,253		332,253	(189,889)	142,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8	8		8		8			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	TOTAL Special Cost Centers			41,618	41,618		41,618		41,618			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,343,379	416,459	1,112,193	2,872,031		2,872,031	(203,378)	2,668,653			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:

10/1/09

Ending:

9/30/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,157)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(374)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,970)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,654)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(136)	20		28
29	Other-Attach Schedule	(2,877)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,178)		\$	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)	(177,200)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (177,200)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (203,378)		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		9,317	10.2	42
43	Prescription Drugs	X		160,436	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 169,753		47

BHF USE ONLY

48		49		50		51		52	
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MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/09

Ending: 9/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	\$ (1,325)	20	1
2	MISCELLANEOUS INCOME	(694)	21	2
3	RESIDENT TRANSPORTATION	(575)	14	3
4	COMMISSION ON COLLECTIONS	(283)	21	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	(2,877)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/1/09

Ending:

9/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(374)	0	0	0	0	0	0	0	0	0	0	(374)	2
3	Housekeeping	0	0	151	0	0	0	0	0	0	0	0	151	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	54	0	0	0	0	0	0	0	0	54	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(374)	0	205	0	(169)	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	19,394	0	0	0	0	0	0	0	0	0	19,394	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	(575)	0	0	0	0	0	0	0	0	0	0	(575)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(575)	19,394	0	0	0	0	0	0	0	0	0	18,819	16
	C. General Administration													
17	Administrative	0	7,249	0	0	0	0	0	0	0	0	0	7,249	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,970)	(86,450)	0	0	0	0	0	0	0	0	0	(94,420)	19
20	Fees, Subscriptions & Promotions	(15,115)	0	73	0	0	0	0	0	0	0	0	(15,042)	20
21	Clerical & General Office Expenses	(987)	52,395	0	0	0	0	0	0	0	0	0	51,408	21
22	Employee Benefits & Payroll Taxes	0	12,854	0	0	0	0	0	0	0	0	0	12,854	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,360	0	0	0	0	0	0	0	0	0	5,360	24
25	Other Admin. Staff Transportation	0	0	413	0	0	0	0	0	0	0	0	413	25
26	Insurance-Prop.Liab.Malpractice	0	0	39	0	0	0	0	0	0	0	0	39	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(24,072)	(8,592)	525	0	(32,139)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,021)	10,802	730	0	(13,489)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/1/09

Ending:

9/30/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	17,760	0	0	0	0	0	0	0	0	0	17,760	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(1,157)	34,344	0	0	0	0	0	0	0	0	0	33,187	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(242,950)	0	0	0	0	0	0	0	0	0	(242,950)	34
35	Rent-Equipment & Vehicles	0	1,933	0	0	0	0	0	0	0	0	0	1,933	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,157)	(188,732)	0	(189,889)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(26,178)	(177,930)	730	0	(203,378)	45							

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	COMMUNITY	BALLWIN, MO	HOME OFFICE
		BARRY COMMUNITY CARE CENTER	BARRY	CARE CENTERS		
				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%	34,344	34,344	2
3	V	30 DEPRECIATION		JAMES J. GIARDINA	100.00%	17,760	17,760	3
4	V	31 AMORTIZATION		JAMES J. GIARDINA	100.00%	181	181	4
5	V	19 HOME OFFICE	88,800	COMMUNITY CARE CENTERS, INC.	COMMON		(88,800)	5
6	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,850	7,850	6
7	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,933	1,933	7
8	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	19,394	19,394	8
9	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,249	7,249	9
10	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	52,395	52,395	10
11	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	12,854	12,854	11
12	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,350	2,350	12
13	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,360	5,360	13
14	Total		\$ 339,600			\$ 161,670	\$ * (177,930)	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: 10/1/09

Ending: 9/30/10

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	25 HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC.	COMMON	\$ 413	\$ 413	15
16	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	54	54	16
17	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	73	73	17
18	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	39	39	18
19	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	151	151	19
20	V	22 WORKERS COMP INS	55,390	RISA	25.00%	55,390		20
21	V	26 LIABILITY INS	30,400	RISA	25.00%	30,400		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		\$ 85,790			\$ 86,520	\$ *	730 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:

10/1/09

Ending:

9/30/10

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	\$ 5,619	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,630	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	\$ 7,249		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:

10/1/09

Ending: 9/30/10

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 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	WEST COUNTY CARE CENTER				\$	\$	5,678,126	\$ 276,770	1
2	ST GENEVIEVE CARE CTR						2,689,168	84,968	2
3	CCC OF LEMAY						2,500,368	87,413	3
4	SALEM CARE CENTER						1,977,805	63,059	4
5	MONMOUTH NH						2,511,996	83,118	5
6	MAR-KA NH						2,783,231	110,115	6
7	CCC OF SENECA						3,020,591	111,698	7
8	MT VERNON PLACE CARE						2,617,962	92,474	8
9	COUNTRY VIEW NH						2,278,766	77,007	9
10	MERAMEC NH						3,007,762	104,114	10
11	SEVILLE CARE CENTER						3,409,016	108,235	11
12	SALEM RES CARE						565,722	27,565	12
13	CARL JUNCTION RES CARE						665,490	30,637	13
14	MT VERNON RES CARE						460,102	24,313	14
15	SENECA HOME PLACE						379,647	21,836	15
16	HUDSON HOUSE						486,419	25,124	16
17	MAPLE GROVE LODGE						3,018,130	101,922	17
18	CCC OF AURORA						4,381,526	135,650	18
19	BARRY COMMUNITY CARE						3,025,157	97,482	19
20	LICKING RESIDENTIAL CTR						409,553	28,849	20
21	CCC OF GAINESVILLE						2,981,165	96,128	21
22	AL OF SILVER CREEK						827,976	35,643	22
23	CCC OF LICKING						2,336,486	76,274	23
24	COMMUNITY IN HOME						986,510	31,090	24
25	TOTALS				\$	\$		\$ 1,931,484	25

Facility Name & ID Number

MAR KA NURSING HOME

0031740

Report Period Beginning:

10/1/09

Ending:

9/30/10

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										
										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	US BANK	X	2002 CHEVY VAN	\$294.41	4/24/09	\$ 14,000	\$ 10,763	4/24/2014	9.5600	\$ 1,154	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$294.41		\$ 14,000	\$ 10,763			\$ 1,154	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 14,000	\$ 10,763			\$ 1,154	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	35,100		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	48,840		2
3. Under or (over) accrual (line 2 minus line 1).		\$	13,740		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	36,900		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	50,640		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	36,136	8	FOR BHF USE ONLY	
	2006	38,852	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
	2007	37,534	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2008	46,529	11	15	LESS REFUND FROM LINE 6 \$ 15
	2009	48,840	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

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Ending:

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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 Use	2 Square Feet	3 Year Acquired	4 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:

10/1/09

Ending:

9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1986	\$ 950,000	\$ 17,760	22.5	\$ 17,760		\$ 950,000	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

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10/1/09

Ending:

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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 (\$20,641 desk audit adj off)	2004							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			2,962	48
49	GUTTERING & DOWNSPOUTS	2006	8,000		Lease Life			8,000	49
50	81 GAL WATER HEATER	2007	4,030		Lease Life			4,030	50
51	ROOF 300 WING	2007	17,000		Lease Life			17,000	51
52	CHANDELIER	2007	2,075		Lease Life			2,075	52
53	BRICK SIGNS	2008	6,450		Lease Life			6,450	53
54	LANDSCAPING IMPROVEMENTS	2008	1,800		Lease Life			1,800	54
55	UPGRADE WANDERGUARD SYST	2009	3,922	1,426	Lease Life	1,426		2,258	55
56	FLAT ROOF	2009	18,669	7,001	Lease Life	7,001		10,501	56
57	ALUMINUM COATING ROOF	2009	2,775	1,074	Lease Life	1,074		1,432	57
58	BOILER MOTOR & LOUVER	2010	1,594	736	Lease Life	736		736	58
59	GARAGE ROOF	2010	1,007	265	Lease Life	265		265	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)		\$ 1,249,223	\$ 28,262		\$ 28,262	\$	\$ 1,236,448	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 183,702	\$ 10,946	\$ 10,946	\$		\$ 154,353	71
72	Current Year Purchases	8,720	852	852			852	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 192,422	\$ 11,798	\$ 11,798	\$		\$ 155,205	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	Facility	2002 Chevy Express Van	2009	\$ 20,346	\$ 5,087	\$ 5,087	\$	4	\$ 7,206	76
77		New Engine for 2002 Chevy	2010	12,938	539	539		4	539	77
78										78
79										79
80	TOTALS			\$ 33,284	\$ 5,626	\$ 5,626	\$		\$ 7,745	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)	\$ 1,549,929	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,686	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,686	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,399,398	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 1,733 Description: STORAGE RENTAL \$1,560 OTHER \$173

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	929	\$ 61,262	\$	929	\$ 61,262	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		183	16,909		183	16,909	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,244	84,382		1,244	84,382	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	2,356	\$ 162,553	\$	2,356	\$ 162,553	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**

0031740

Report Period Beginning: **10/1/09**

Ending: **9/30/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/10**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 29,347	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>24,754</u>)	507,071		3
4	Supply Inventory (priced at)	1,500		4
5	Short-Term Investments	7,326		5
6	Prepaid Insurance	15,101		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(823,704)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (263,359)	\$	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	293,904		15
16	Equipment, at Historical Cost	225,707		16
17	Accumulated Depreciation (book methods)	(444,080)		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):	245		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 75,776	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (187,583)	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 832,328	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,512		28
29	Short-Term Notes Payable	2,625		29
30	Accrued Salaries Payable	85,521		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,452		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,900		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>	171,000		36
37	<u>Due to Medicare</u>	12,397		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,167,735	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	8,138		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)	\$ 8,138	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,175,873	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,363,456)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (187,583)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,208,821)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,208,820)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(154,636)	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)	\$ (154,636)	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)	\$ (1,363,456)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,288,970	1
2	Discounts and Allowances for all Levels	(9,320,705)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,968,265	3
B. Ancillary Revenue			
4	Day Care	13,995	4
5	Other Care for Outpatients		5
6	Therapy	388,448	6
7	Oxygen	343,038	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 745,481	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,245	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,245	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,157	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,157	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RESIDENT TRANSPORTATION/MISC INCOME	247	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 247	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,717,395	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	614,694	31
32	Health Care	1,350,802	32
33	General Administration	532,664	33
B. Capital Expense			
34	Ownership	332,253	34
C. Ancillary Expense			
35	Special Cost Centers	8	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)*	\$ 2,872,031	40
41	Income before Income Taxes (line 30 minus line 40)**	(154,636)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (154,636)	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
DEPRECIATION
DIFFERENCE

*** 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:

10/1/09

Ending:

9/30/10

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	433	433	\$ 10,834	\$ 25.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,717	4,933	109,833	22.26	3
4	Licensed Practical Nurses	18,295	19,235	336,644	17.50	4
5	CNAs & Orderlies	37,572	38,863	370,201	9.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,959	2,095	26,243	12.53	9
10	Activity Assistants	329	333	2,698	8.10	10
11	Social Service Workers	3,604	3,858	43,283	11.22	11
12	Dietician					12
13	Food Service Supervisor	2,030	2,141	25,623	11.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,619	4,973	50,372	10.13	15
16	Dishwashers	9,544	9,992	90,788	9.09	16
17	Maintenance Workers	1,756	2,006	31,639	15.77	17
18	Housekeepers	8,081	8,944	93,636	10.47	18
19	Laundry	5,712	6,041	50,499	8.36	19
20	Administrator	2,032	2,080	60,322	29.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,976	2,104	27,950	13.28	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	1,374	1,420	12,814	9.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,033	109,451	\$ 1,343,379 *	\$ 12.27	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	88	\$ 3,095	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	51	2,295	10.3	37
38	Nurse Consultant		1,558	10.3	38
39	Pharmacist Consultant	56	1,748	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	7	463	11.3	44
45	Social Service Consultant	7	463	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	257	\$ 15,622		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1	\$ 100	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1	\$ 100		53

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/1/09

Ending: 9/30/10

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 HEALTH CARE ASSOC \$4,195
- (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. \$ 1,686 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. See travel schedule
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? 58%
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.