

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

<p>I. IDPH License ID Number: <u>0031740</u></p> <p>Facility Name: <u>MAR KA NURSING HOME</u></p> <p>Address: <u>201 SOUTH 10TH STREET</u> <u>MASCOUTAH</u> <u>62258</u> <small>Number City Zip Code</small></p> <p>County: <u>ST. CLAIR</u></p> <p>Telephone Number: <u>(618) 566-8000</u> Fax # <u>()</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>12/23/86</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>YVONNE CHUA</u> Telephone Number: <u>(636) 394-3000</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/11</u> to <u>9/30/12</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>JAMES J. GIARDINA</u> (Title) _____ </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JAMES J. GIARDINA</u> (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JAMES J. GIARDINA</u> (Title) _____							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>							

Facility Name & ID Number MAR KA NURSING HOME

0031740 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	27,816	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	27,816	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	9,432	7,920	1,401	18,753	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,432	7,920	1,401	18,753	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.42%

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 1,068

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: 9/30/12 Fiscal Year: 9/30/12

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

Facility Name & ID Number

MAR KA NURSING HOME

0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

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	172,985	12,163	3,127	188,275		188,275		188,275		1
2	Food Purchase		98,594		98,594		98,594	(373)	98,221		2
3	Housekeeping	75,486	14,793		90,279		90,279	131	90,410		3
4	Laundry	53,102	9,642		62,744		62,744		62,744		4
5	Heat and Other Utilities			58,649	58,649		58,649		58,649		5
6	Maintenance	29,910	24,657	33,385	87,952		87,952	131	88,083		6
7	Other (specify):*										7
8	TOTAL General Services	331,483	159,849	95,161	586,493		586,493	(111)	586,382		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	900,640	168,599	8,420	1,077,659		1,077,659	19,728	1,097,387		10
10a	Therapy		584	129,580	130,164		130,164		130,164		10a
11	Activities	38,760	6,604	2,758	48,122		48,122		48,122		11
12	Social Services	43,120		561	43,681		43,681		43,681		12
13	CNA Training										13
14	Program Transportation			149	149		149	(917)	(768)		14
15	Other (specify):* Ambulance			491	491		491		491		15
16	TOTAL Health Care and Programs	982,520	175,787	147,959	1,306,266		1,306,266	18,811	1,325,077		16
	C. General Administration										
17	Administrative	62,402			62,402		62,402	9,236	71,638		17
18	Directors Fees										18
19	Professional Services			137,606	137,606		137,606	(87,103)	50,503		19
20	Dues, Fees, Subscriptions & Promotions			45,546	45,546		45,546	(22,246)	23,300		20
21	Clerical & General Office Expenses	22,649	6,774	27,658	57,081		57,081	41,869	98,950		21
22	Employee Benefits & Payroll Taxes			206,171	206,171		206,171	10,291	216,462		22
23	Inservice Training & Education			644	644		644		644		23
24	Travel and Seminar			2,019	2,019		2,019	3,778	5,797		24
25	Other Admin. Staff Transportation							350	350		25
26	Insurance-Prop.Liab.Malpractice			36,130	36,130		36,130	35	36,165		26
27	Other (specify):*										27
28	TOTAL General Administration	85,051	6,774	455,774	547,599		547,599	(43,790)	503,809		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,399,054	342,410	698,894	2,440,358		2,440,358	(25,090)	2,415,268		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:

10/1/11

Ending:

9/30/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,941	45,941	45,941	(229)	45,712				30
31	Amortization of Pre-Op. & Org.						181	181				31
32	Interest			3,691	3,691	3,691	18,359	22,050				32
33	Real Estate Taxes			52,569	52,569	52,569		52,569				33
34	Rent-Facility & Grounds			250,800	250,800	250,800	(245,194)	5,606				34
35	Rent-Equipment & Vehicles			2,566	2,566	2,566	1,169	3,735				35
36	Other (specify):*											36
37	TOTAL Ownership			355,567	355,567	355,567	(225,714)	129,853				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,666	144,666	144,666		144,666				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			144,666	144,666	144,666		144,666				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,399,054	342,410	1,199,127	2,940,591	2,940,591	(250,804)	2,689,787				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: 10/1/11

Ending: 9/30/12

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	(229)	30		9
10	Interest and Other Investment Income	(2,689)	32		10
11	Discounts, Allowances, Rebates & Refunds	(38)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	2		13
14	Non-Care Related Interest	(1,002)	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	(5,517)	21		18
19	Entertainment				19
20	Contributions	(85)	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	(20,639)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(135)	20		28
29	Other-Attach Schedule	(2,630)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,337)		\$	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)	(217,467)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,467)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (250,804)		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		9,681	10.2	42
43	Prescription Drugs	X		92,643	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 102,324		47

BHF USE ONLY						
48		49		50		51
						52

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/11

Ending: 9/30/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NONALLOWABLE IHCA DUES	\$ (1,542)	20	1
2	MISCELLANEOUS INCOME	(171)	21	2
3	RESIDENT TRANSPORTATION	(917)	14	3
4	COMMISSION ON COLLECTIONS		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		(2,630)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(373)	0	0	0	0	0	0	0	0	0	0	(373)	2
3	Housekeeping	0	0	131	0	0	0	0	0	0	0	0	131	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	131	0	0	0	0	0	0	0	0	131	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(373)	0	262	0	(111)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	19,728	0	0	0	0	0	0	0	0	19,728	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	(917)	0	0	0	0	0	0	0	0	0	0	(917)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(917)	0	19,728	0	18,811	16							
	C. General Administration													
17	Administrative	0	0	9,236	0	0	0	0	0	0	0	0	9,236	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(87,103)	0	0	0	0	0	0	0	0	(87,103)	19
20	Fees, Subscriptions & Promotions	(22,316)	0	70	0	0	0	0	0	0	0	0	(22,246)	20
21	Clerical & General Office Expenses	(5,811)	0	47,680	0	0	0	0	0	0	0	0	41,869	21
22	Employee Benefits & Payroll Taxes	0	0	10,291	0	0	0	0	0	0	0	0	10,291	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,778	0	0	0	0	0	0	0	0	3,778	24
25	Other Admin. Staff Transportation	0	0	350	0	0	0	0	0	0	0	0	350	25
26	Insurance-Prop.Liab.Malpractice	0	0	35	0	0	0	0	0	0	0	0	35	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,127)	0	(15,663)	0	(43,790)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,417)	0	4,327	0	(25,090)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

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	(229)	0	0	0	0	0	0	0	0	0	0	(229)	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(3,691)	22,050	0	0	0	0	0	0	0	0	0	18,359	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(250,800)	5,606	0	0	0	0	0	0	0	0	(245,194)	34
35	Rent-Equipment & Vehicles	0	0	1,169	0	0	0	0	0	0	0	0	1,169	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,920)	(228,569)	6,775	0	(225,714)	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)	(33,337)	(228,569)	11,102	0	0	0	0	0	0	0	0	(250,804)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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%	22,050	22,050	2
3	V	30 DEPRECIATION		JAMES J. GIARDINA	100.00%			3
4	V	31 AMORTIZATION		JAMES J. GIARDINA	100.00%	181	181	4
5	V							5
6	V							6
7	V							7
8	V	22 WORKERS COMP INS	35,230	RISA	25.00%	35,230		8
9	V	26 LIABILITY INS	30,400	RISA	25.00%	30,400		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 316,430			\$ 87,861	\$ * (228,569)	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: 10/1/11

Ending: 9/30/12

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	19 HOME OFFICE	\$ 88,800	COMMUNITY CARE CENTERS, INC.	COMMON	\$	\$ (88,800)	15
16	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,606	5,606	16
17	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,169	1,169	17
18	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	19,728	19,728	18
19	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,236	9,236	19
20	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	47,680	47,680	20
21	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,291	10,291	21
22	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,697	1,697	22
23	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	3,778	3,778	23
24	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	350	350	24
25	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131	25
26	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	70	70	26
27	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	35	35	27
28	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131	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		\$ 88,800			\$ 99,902	\$ * 11,102	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:

10/1/11

Ending:

9/30/12

VII. RELATED PARTIES

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

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	2	4.00	SALARY	\$ 7,599	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,637	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	\$ 9,236		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:

10/1/11

Ending:

9/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

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				\$	\$	5,712,687	\$ 222,965	1
2	ST GENEVIEVE CARE CTR						2,736,922	75,831	2
3	CCC OF LEMAY						2,734,877	85,987	3
4	SALEM CARE CENTER						1,990,818	54,961	4
5	MONMOUTH NH						2,857,134	90,847	5
6	MAR-KA NH						2,854,966	99,902	6
7	CCC OF SENECA						3,366,439	94,140	7
8	MT VERNON PLACE CARE						3,033,296	106,245	8
9	COUNTRY VIEW NH						2,441,372	67,992	9
10	MERAMEC NH						2,849,994	87,430	10
11	SEVILLE CARE CENTER						3,544,114	98,318	11
12	SALEM RES CARE						615,589	26,227	12
13	CARL JUNCTION RES CARE						710,870	28,755	13
14	MT VERNON RES CARE						483,587	22,726	14
15	SENECA HOME PLACE						453,327	21,923	15
16	HUDSON HOUSE						578,540	25,244	16
17	MAPLE GROVE LODGE						3,621,305	105,742	17
18	CCC OF AURORA						4,611,039	123,394	18
19	BARRY COMMUNITY CARE						3,247,414	102,271	19
20	LICKING RESIDENTIAL CTR						402,502	20,573	20
21	CCC OF GAINESVILLE						3,503,568	100,467	21
22	AL OF SILVER CREEK						775,678	31,012	22
23	MARK TWAIN MANOR						5,904,401	172,752	23
24	CCC OF LICKING						2,675,286	74,197	24
25	TOTALS				\$	\$		\$ 1,939,901	25

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/1/11

Ending: 9/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	COMMUNITY IN HOME				\$	\$	1,035,825	27,477	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		27,477	25

Facility Name & ID Number

MAR KA NURSING HOME

0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	\$ 5,268	4/24/14	9.5600	\$ 655	1						
2	REGIONS BANK		X	SPRINKLER SYSTEM		12/19/11	142,000		6/30/12	3.5388	2,034	2						
3												3						
4												4						
5												5						
Working Capital																		
6	REGIONS BANK		X	LOC		12/19/11	2,887	410,000	12/17/12	3.5190		6						
7	DUE TO SHAREHOLDER										1,002	7						
8												8						
9	TOTAL Facility Related				\$294.41		\$ 158,887	\$ 415,268			\$ 3,691	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 158,887	\$ 415,268			\$ 3,691	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 2011 report.		\$	37,350	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.)		\$	51,219	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	13,869	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	38,700	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.		\$	52,569	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	37,534	8		
	2008	46,529	9		
	2009	48,840	10		
	2010	49,565	11		
	2011	51,219	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAR KA NURSING HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0031740

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE (636) 394-3000 FAX #: (636) 394-7713

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-31.01-114-007</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ <u>50,951.30</u>	\$ <u>50,951.30</u>
2. _____	<u>BLK/RG-6W PT LOT 12C</u>	\$ _____	\$ _____
3. _____	<u>DOC A01700220</u>	\$ _____	\$ _____
4. <u>10-31.0-113-009</u>	<u>LOT/SEC-18 BK 2659-1974</u>	\$ <u>267.20</u>	\$ <u>267.20</u>
5. <u>10-31.0-114-009</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ _____	\$ _____
6. _____	<u>BLK/RG-6W BK 2659-1974</u>	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>51,218.50</u></u>	\$ <u><u>51,218.50</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number MAR KA NURSING HOME

0031740 Report Period Beginning:

10/1/11 Ending:

9/30/12

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>1986</u>	<u>\$ 75,000</u>	1
2					2
3	TOTALS	48,000		\$ 75,000	3

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

0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

XI. OWNERSHIP COSTS (continued)

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

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

Report Period Beginning:

10/1/11

Ending:

9/30/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	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 (\$6,450 orig--desk audit reduced to \$2,867 in 2012)	2007	2,867		Lease Life			2,867	53
54	LANDSCAPING IMPROVEMENTS (\$1,800 desk audit adj 2012)	2008							54
55	UPGRADE WANDERGUARD SYST	2009	3,922	238	Lease Life	238		3,922	55
56	FLAT ROOF	2009	18,669	1,167	Lease Life	1,167		18,669	56
57	ALUMINUM COATING ROOF	2009	2,775	268	Lease Life	268		2,775	57
58	BOILER MOTOR & LOUVER (\$1,594 desk audit adj 2012)	2010		123			(123)		58
59	GARAGE ROOF (\$1,007 desk audit adj 2012)	2010		106			(106)		59
60	2 FIRE RATED DOORS	2011	4,756	951	Lease Life	951		4,756	60
61	OFFICE A/C 9000 BTU	2011	3,438	1,146	Lease Life	1,146		3,438	61
62	NEW SPRINKLER SYSTEM	2012	142,937	26,800	Lease Life	26,800		26,800	62
63	NEW FIRE ALARM PANEL	2012	4,549	853	Lease Life	853		853	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,396,919	\$ 31,652		\$ 31,423	\$ (229)	\$ 1,277,086	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 195,893	\$ 5,813	\$ 5,813	\$		\$ 169,294	71
72	Current Year Purchases	2,743	155	155			155	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 198,636	\$ 5,968	\$ 5,968	\$		\$ 169,449	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2002 Chevy Express Van	2009	\$ 20,346	\$ 5,087	\$ 5,087	\$	4	\$ 17,379	76
77		New Engine for 2002 Chevy	2010	12,938	3,234	3,234		4	7,008	77
78										78
79										79
80	TOTALS			\$ 33,284	\$ 8,321	\$ 8,321	\$		\$ 24,387	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)	\$ 1,703,839	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,941	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,712	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (229)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,470,922	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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 2,566 Description: STORAGE \$1,560; GEN TESTING \$115; OXYGEN TANKS \$273; BEDS \$600; HELIUM TANK \$18

(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: 10/1/11 Ending: 9/30/12
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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a.2&3	hrs	\$	685	\$ 49,241	\$ 196	685	\$ 49,437	1	
2	Licensed Speech and Language Development Therapist	10a.2&3	hrs		120	8,135		120	8,135	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a.2&3	hrs		979	72,204	388	979	72,592	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			\$	1,784	\$ 129,580	\$ 584	1,784	\$ 130,164	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: **10/1/11**

Ending:

9/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/12** (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	\$ 17,765	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	595,527		3
4	Supply Inventory (priced at)	1,350		4
5	Short-Term Investments	3,123		5
6	Prepaid Insurance	12,813		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due To/From R/P	(834,831)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (204,253)	\$	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	449,584		15
16	Equipment, at Historical Cost	231,921		16
17	Accumulated Depreciation (book methods)	(523,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 157,917	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (46,336)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 980,773	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,466		28
29	Short-Term Notes Payable	3,175		29
30	Accrued Salaries Payable	87,824		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,392		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,700		32
33	Accrued Interest Payable	1,002		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Due To/From Related Parties	339,925		36
37	Est insurance liab	233,814		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,706,071	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	412,093		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)	\$ 412,093	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,118,164	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,164,500)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (46,336)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,680,234)	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT-BAD DEBTS/AR	(5,913)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,686,147)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(478,353)	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)	\$ (478,353)	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)	\$ (2,164,500)	24 *

* This must agree with page 17, line 47.

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 15,940,050	1	
2	Discounts and Allowances for all Levels	(14,009,024)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,931,026	3	
B. Ancillary Revenue				
4	Day Care	5,155	4	
5	Other Care for Outpatients		5	
6	Therapy	325,185	6	
7	Oxygen	196,380	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 526,720	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	1,091	22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,091	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	2,275	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,275	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	RES TRANSP/MISC INCOME/AP TRADE DISCOUNT	1,126	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,126	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,462,238	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	586,493	31	
32	Health Care	1,306,266	32	
33	General Administration	547,599	33	
B. Capital Expense				
34	Ownership	355,567	34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee	144,666	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,940,591	40	
41	Income before Income Taxes (line 30 minus line 40)**	(478,353)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (478,353)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 970,928	44
45	Private Pay - Net Inpatient Revenue	888,841	45
46	Medicare - Net Inpatient Revenue	39,359	46
47	Other-(specify) <u>Hospice</u>	34,522	47
48	Other-(specify) <u>Prior Yr C/A, Bad Debts</u>	(2,624)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,931,026	49

* 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:

10/1/11

Ending:

9/30/12

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	2,032	2,080	\$ 53,896	\$ 25.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,348	6,636	151,765	22.87	3
4	Licensed Practical Nurses	16,105	16,877	298,635	17.69	4
5	CNAs & Orderlies	37,639	39,233	382,891	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,888	2,024	26,857	13.27	9
10	Activity Assistants	1,329	1,383	11,903	8.61	10
11	Social Service Workers	3,532	3,820	43,120	11.29	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,248	28,859	12.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,627	6,979	69,513	9.96	15
16	Dishwashers	7,540	7,939	74,613	9.40	16
17	Maintenance Workers	1,582	1,814	29,910	16.49	17
18	Housekeepers	7,052	7,602	75,486	9.93	18
19	Laundry	5,683	6,030	53,102	8.81	19
20	Administrator	2,008	2,080	62,402	30.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,738	1,826	22,649	12.40	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	1,333	1,405	13,453	9.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,556	109,976	\$ 1,399,054 *	\$ 12.72	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	90	\$ 3,127	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	46	2,070	10.3	37
38	Nurse Consultant	1	395	10.3	38
39	Pharmacist Consultant	48	4,339	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	8	561	11.3	44
45	Social Service Consultant	8	561	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	249	\$ 17,053		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1	\$ 180	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1	\$ 180		53

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

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

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning: 10/1/11

Ending: 9/30/12

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. \$ 3,027 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. \$ 144,666
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 Attached 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 72%
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? NO
Firm Name: _____
- (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? YES
Attach invoices and a summary of services for all architect and appraisal fees.