



Facility Name & ID Number MAR KA NURSING HOME

# 0031740 Report Period Beginning: 10/1/14 Ending: 9/30/15

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,791	9,756	2,145	19,692	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,791	9,756	2,145	19,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.99%

D. How many bed-hold days during this year were paid by the Department? NONE (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 \_\_\_\_\_

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: 9/30/15 Fiscal Year: 9/30/15

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	179,570	11,318	3,272	194,160		194,160		194,160	1	
2	Food Purchase		112,287		112,287		112,287	(646)	111,641	2	
3	Housekeeping	85,190	13,878		99,068		99,068	132	99,200	3	
4	Laundry	61,593	18,195		79,788		79,788		79,788	4	
5	Heat and Other Utilities			68,938	68,938		68,938		68,938	5	
6	Maintenance	24,434	35,683	66,183	126,300		126,300	171	126,471	6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	350,787	191,361	138,393	680,541		680,541	(343)	680,198	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,500	6,500		6,500		6,500	9	
10	Nursing and Medical Records	955,704	65,242	7,283	1,028,229		1,028,229	26,364	1,054,593	10	
10a	Therapy		90	126,094	126,184		126,184		126,184	10a	
11	Activities	47,405	7,257	5,392	60,054		60,054		60,054	11	
12	Social Services	45,595	57	639	46,291		46,291		46,291	12	
13	CNA Training									13	
14	Program Transportation			654	654		654		654	14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	1,048,704	72,646	146,562	1,267,912		1,267,912	26,364	1,294,276	16	
	<b>C. General Administration</b>										
17	Administrative	66,442			66,442		66,442	9,839	76,281	17	
18	Directors Fees			2,400	2,400		2,400		2,400	18	
19	Professional Services			161,697	161,697		161,697	(128,474)	33,223	19	
20	Dues, Fees, Subscriptions & Promotions			45,101	45,101		45,101	(18,913)	26,188	20	
21	Clerical & General Office Expenses	24,393	9,947	34,589	68,929		68,929	44,583	113,512	21	
22	Employee Benefits & Payroll Taxes			230,440	230,440		230,440	10,418	240,858	22	
23	Inservice Training & Education			662	662		662		662	23	
24	Travel and Seminar							3,474	3,474	24	
25	Other Admin. Staff Transportation							677	677	25	
26	Insurance-Prop.Liab.Malpractice			42,822	42,822		42,822	39	42,861	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	90,835	9,947	517,711	618,493		618,493	(78,357)	540,136	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,490,326	273,954	802,666	2,566,946		2,566,946	(52,336)	2,514,610	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:

10/1/14

Ending:

9/30/15

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			21,424	21,424		21,424		21,424			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest			6,288	6,288		6,288	17,361	23,649			32
33	Real Estate Taxes			50,866	50,866		50,866		50,866			33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(66,445)	5,555			34
35	Rent-Equipment & Vehicles			1,837	1,837		1,837	2,487	4,324			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			152,415	152,415		152,415	(46,416)	105,999			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,419		128,419		128,419		128,419			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,956	151,956		151,956		151,956			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		128,419	151,956	280,375		280,375		280,375			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,490,326	402,373	1,107,037	2,999,736		2,999,736	(98,752)	2,900,984			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: 10/1/14

Ending: 9/30/15

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(137)	2		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	(795)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(509)	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	(2,449)	21		18
19	Entertainment				19
20	Contributions	(150)	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	(18,803)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(208)	20		28
29	Other-Attach Schedule	(2,995)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (26,046)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(72,706)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (72,706)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (98,752)</b>		<b>37</b>

\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>						
48		49		50		51
						52

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/14

Ending: 9/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NONALLOWABLE IHCA DUES	\$ (1,700)	21	1
2	MISCELLANEOUS INCOME	(1,295)	21	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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(2,995)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(646)	0	0	0	0	0	0	0	0	0	0	(646)	2
3	Housekeeping	0	0	132	0	0	0	0	0	0	0	0	132	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	171	0	0	0	0	0	0	0	0	171	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(646)</b>	<b>0</b>	<b>303</b>	<b>0</b>	<b>(343)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	26,364	0	0	0	0	0	0	0	0	26,364	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>26,364</b>	<b>0</b>	<b>26,364</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	9,839	0	0	0	0	0	0	0	0	9,839	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(128,474)	0	0	0	0	0	0	0	0	(128,474)	19
20	Fees, Subscriptions & Promotions	(19,011)	0	98	0	0	0	0	0	0	0	0	(18,913)	20
21	Clerical & General Office Expenses	(5,594)	0	50,177	0	0	0	0	0	0	0	0	44,583	21
22	Employee Benefits & Payroll Taxes	0	0	10,418	0	0	0	0	0	0	0	0	10,418	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,474	0	0	0	0	0	0	0	0	3,474	24
25	Other Admin. Staff Transportation	0	0	677	0	0	0	0	0	0	0	0	677	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	<b>TOTAL General Administration</b>	<b>(24,605)</b>	<b>0</b>	<b>(53,752)</b>	<b>0</b>	<b>(78,357)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(25,251)</b>	<b>0</b>	<b>(27,085)</b>	<b>0</b>	<b>(52,336)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(795)	18,156	0	0	0	0	0	0	0	0	0	17,361	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(72,000)	5,555	0	0	0	0	0	0	0	0	(66,445)	34
35	Rent-Equipment & Vehicles	0	0	2,487	0	0	0	0	0	0	0	0	2,487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(795)</b>	<b>(53,663)</b>	<b>8,042</b>	<b>0</b>	<b>(46,416)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(26,046)</b>	<b>(53,663)</b>	<b>(19,043)</b>	<b>0</b>	<b>(98,752)</b>	<b>45</b>							

Facility Name & ID Number

MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 BUILDING RENT	\$ 72,000	JAMES J. GIARDINA	100.00%	\$	\$ (72,000)	1
2	V	32 INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	18,156	18,156	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							8
9	V	26 LIABILITY INS	26,600	RISA	25.00%	26,600		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 98,600			\$ 44,937	\$ * (53,663)	14

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

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	\$ 129,600	COMMUNITY CARE CENTERS, INC.	COMMON	\$	\$ (129,600)
16	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,555	5,555
17	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,487	2,487
18	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	26,364	26,364
19	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,839	9,839
20	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	50,177	50,177
21	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,418	10,418
22	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,126	1,126
23	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	3,474	3,474
24	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	677	677
25	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	171	171
26	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	98	98
27	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	39	39
28	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	132	132
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 129,600			\$ 110,557	\$ * (19,043)

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

**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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							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	<b>Total</b>		\$			\$	0	\$ *	39

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

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

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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	<b>Total</b>		\$			\$	0	\$ *

\* 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:

10/1/14

Ending:

9/30/15

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:

10/1/14

Ending:

9/30/15

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: 10/1/14 Ending: 9/30/15

## 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	\$ 7,724	17.7	1
2	JESSICA CRANE	SECRETARY			NONE	3	6.00	SALARY	843	17.7	2
3	MARY SCHAPER	SECRETARY			NONE	2	4.00	SALARY	1,272	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,839		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:

10/1/14

Ending: 9/30/15

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				\$	\$	5,372,369	\$ 161,690	1
2	ST GENEVIEVE CARE CTR						2,761,386	81,581	2
3	CCC OF LEMAY						2,835,048	96,608	3
4	SALEM CARE CENTER						2,010,928	59,024	4
5	MONMOUTH NH						2,918,842	87,447	5
6	MAR-KA NH						2,870,136	110,557	6
7	CCC OF SENECA						3,421,590	98,556	7
8	MT VERNON PLACE CARE						2,933,603	92,002	8
9	COUNTRY VIEW NH						2,429,561	107,373	9
10	MERAMEC NH						2,875,470	95,102	10
11	SEVILLE CARE CENTER						3,442,240	108,489	11
12	SALEM RES CARE						626,780	27,720	12
13	CARL JUNCTION RES CARE						713,170	30,078	13
14	MT VERNON RES CARE						471,981	23,499	14
15	SENECA HOME PLACE						531,306	25,113	15
16	HUDSON HOUSE						632,047	27,860	16
17	MAPLE GROVE LODGE						3,265,527	139,553	17
18	CCC OF AURORA						4,395,027	119,928	18
19	BARRY COMMUNITY CARE						3,215,958	97,629	19
20	LICKING RESIDENTIAL CTR						437,484	22,552	20
21	CCC OF GAINESVILLE						3,208,634	87,554	21
22	AL OF SILVER CREEK						805,349	32,590	22
23	MARK TWAIN MANOR						6,256,415	186,853	23
24	CCC OF LICKING						2,551,127	71,689	24
25	TOTALS				\$	\$		\$ 1,991,047	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending: 9/30/15

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  
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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				\$	\$	1,077,834	\$ 29,944	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				\$	\$		\$ 29,944	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending: 9/30/15

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	XEROX		X	COPIER LEASE	\$97.61	3/1/13	\$ 5,038	\$ 2,542	3/1/18	7.0000	\$ 188						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6	REGIONS BANK		X	LOC		12/19/11	2,887	178,214	6/30/16	3.4980	6,100						
7																	
8																	
9	<b>TOTAL Facility Related</b>				\$97.61		\$ 7,925	\$ 180,756			\$ 6,288						
<b>B. Non-Facility Related*</b>																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,925	\$ 180,756			\$ 6,288						

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2014 report.		\$	<b>35,100</b>	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.)		\$	<b>49,066</b>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>13,966</b>	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>36,900</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,866</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<b>49,565</b>	8		
	2011	<b>51,219</b>	9		
	2012	<b>45,454</b>	10		
	2013	<b>46,532</b>	11		
	2014	<b>49,066</b>	12		
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2014 \$ 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.**

## 2014 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 2014 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 2014.

(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>10-31.0-114-007</u>	<u>LOT/SEC-31-SUBL/TWP-1N-</u>	\$ <u>48,859.00</u>	\$ <u>48,859.00</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>207.00</u>	\$ <u>207.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>49,066.00</u></u>	\$ <u><u>49,066.00</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 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 \_\_\_\_\_

TELEPHONE (      ) \_\_\_\_\_ FAX #: (      ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MAR KA NURSING HOME

# 0031740 Report Period Beginning:

10/1/14 Ending:

9/30/15

**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).

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

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

# **0031740**

Report Period Beginning:

10/1/14

Ending:

9/30/15

**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
<b>Improvement Type**</b>										
9	ROOF REPAIR		1989	4,686		10			4,686	9
10	PATIO AND RAMP		1991	3,252		12			3,252	10
11	PATIO ROOF		1991	2,890		10			2,890	11
12	FLAT ROOF		1991	14,000		10			14,000	12
13	ROOF (NORTH WING)		1992	10,000		10			10,000	13
14	ROOF REPAIR		1990	7,055		10			7,055	14
15	SIDING REPAIR		1990	4,276		10			4,276	15
16	SPRINKLER SYSTEM		1993	2,168		25			2,168	16
17	BULLOCK GARAGES		1993	7,176		15			7,176	17
18	5 TON REFRIGERATION UNIT		1995	3,814		10			3,814	18
19	ROOF REPAIR		1995	18,785		10			18,785	19
20	LANDSCAPING - PATIO		1995	3,342		10			3,342	20
21	ROOFING REPAIR		1997	12,732		10			12,732	21
22	AIR CONDITIONING		1997	3,760		10			3,760	22
23	PHONE SYSTEM		1998	3,780		10			3,780	23
24	ELECTRICAL WORK		1999	3,613		20			3,613	24
25	COUNTERTOPS		1999	2,127		20			2,127	25
26	LENNOX 7.5 ROOFTOP UNIT		2000	5,733		10			5,733	26
27	ROOF ON EAST ASH WING		2000	6,400		10			6,400	27
28	MECHANICAL ROOM IMPR		2001	23,797		15			23,797	28
29	FIRE DAMPERS IN DUCT WORK		2001	1,900		15			1,900	29
30	FIRE DAMPERS IN DUCT WORK		2001	3,059		15			3,059	30
31	EXTERIOR KITCHEN DOORS		2002	1,567		20			1,567	31
32	RE-PLATE DOORS		2002	9,398		10			9,398	32
33										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 &amp; ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending:

9/30/15

## 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		Lease Life			3,922	55
56	FLAT ROOF	2009	18,669		Lease Life			18,669	56
57	ALUMINUM COATING ROOF	2009	2,775		Lease Life			2,775	57
58	BOILER MOTOR & LOUVER (\$1,594 desk audit adj 2012)	2010							58
59	GARAGE ROOF (\$1,007 desk audit adj 2012)	2010							59
60	2 FIRE RATED DOORS	2011	4,756		Lease Life			4,756	60
61	OFFICE A/C 9000 BTU	2011	3,438		Lease Life			3,438	61
62	NEW SPRINKLER SYSTEM	2012	142,937	8,934	Lease Life	8,934		142,937	62
63	NEW FIRE ALARM PANEL	2012	4,549	284	Lease Life	284		4,549	63
64	NEW DOOR FOR MED ROOM	2013	1,038	99	Lease Life	99		1,038	64
65	ROOFTOP A/C UNIT	2014	7,172	2,099	Lease Life	2,099		2,624	65
66	65GAL WATER HEATHER KITCHEN	2015	9,930	2,553	Lease Life	2,553		2,553	66
67	5-TON ROOFTOP A/C UNIT 3 PH 208/230V	2015	7,800	1,040	Lease Life	1,040		1,040	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,422,859	\$ 15,009		\$ 15,009	\$	\$ 1,404,174	70

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,422,859	\$ 15,009		\$ 15,009	\$	\$ 1,404,174	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
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,422,859	\$ 15,009		\$ 15,009	\$	\$ 1,404,174	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	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
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	1
2									2
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4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,422,859	\$ 15,009		\$ 15,009	\$	\$ 1,404,174	1
2									2
3									3
4									4
5									5
6									6
7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,859	\$ 15,009		\$ 15,009	\$	\$ 1,404,174	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>1,422,859</b>	\$ <b>15,009</b>		\$ <b>15,009</b>	\$	\$ <b>1,404,174</b>	34

\*\*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	\$ 194,900	\$ 6,205	\$ 6,205	\$		\$ 171,072	71
72	Current Year Purchases	4,304	210	210			210	72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 199,204	\$ 6,415	\$ 6,415	\$		\$ 171,282	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	\$ 20,347	\$	\$	\$	4	\$ 20,347	76
77		New Engine for 2002 Chevy	2010	12,938				4	12,938	77
78										78
79										79
80	<b>TOTALS</b>			\$ 33,285	\$	\$	\$		\$ 33,285	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)	\$ 1,730,348	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,424	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,424	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)	\$ 1,608,741	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	<b>TOTALS</b>	\$	\$	\$	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: N/A

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. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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: \$ 1,837 Description: STORAGE \$1,560; HELIUM TANK \$48

(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: 10/1/14 Ending: 9/30/15  
**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	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	10.a2&3	hrs	\$	717	\$ 40,010	\$	717	\$ 40,010	1	
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		308	21,355		308	21,355	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10.a2&3	hrs		1,025	64,729	90	1,025	64,819	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39.02	# of prescripts				116,941		116,941	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Lab &amp; X-ray</u>	39.02					11,478		11,478	13	
14	<b>TOTAL</b>			\$	2,050	\$ 126,094	\$ 128,509	2,050	\$ 254,603	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **MAR KA NURSING HOME**# **0031740**Report Period Beginning: **10/1/14**

Ending:

**9/30/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **9/30/15**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 13,703	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,082,251		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,000		5
6	Prepaid Insurance	4,334		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Due from Mcr</b>	12,693		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,113,981	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	479,828		15
16	Equipment, at Historical Cost	232,489		16
17	Accumulated Depreciation (book methods)	(665,711)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 46,606	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,160,587	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,428,044	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,198		28
29	Short-Term Notes Payable	3,582		29
30	Accrued Salaries Payable	94,298		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,308		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
	<b>Other Current Liabilities(specify):</b>			
36	<b>Due To/From R/P; Unpaid Lease</b>	1,336,031		36
37	<b>Reserve A/R Litigation/Est. ins. Liab.</b>	23,641		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,941,002	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	177,174		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 177,174	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,118,176	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,957,589)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,160,587	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (1,887,222)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (1,887,222)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(70,367)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (70,367)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,957,589)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 16,739,470	1
2	Discounts and Allowances for all Levels	(14,465,125)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,274,345</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	399,273	6
7	Oxygen	251,970	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 651,243</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	137	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	1,554	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,691</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	795	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 795</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISC INCOME</b>	1,295	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,295</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,929,369</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	680,541	31
32	Health Care	1,267,912	32
33	General Administration	618,493	33
<b>B. Capital Expense</b>			
34	Ownership	152,415	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	128,419	35
36	Provider Participation Fee	151,956	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,999,736</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(70,367)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (70,367)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,008,558	44
45	Private Pay - Net Inpatient Revenue	1,234,338	45
46	Medicare - Net Inpatient Revenue	620,468	46
47	Other-(specify) <u>HOSPICE</u>	82,355	47
48	Other-(specify) <u>PR YR C/A; PT A ANC; PART B C/A; BAD DEBTS</u>	(671,374)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,274,345</b>	<b>49</b>

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

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

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

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

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

# **0031740**

Report Period Beginning:

**10/1/14**

Ending:

**9/30/15**

**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	2,072	2,080	\$ 58,897	\$ 28.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,404	7,856	183,106	23.31	3
4	Licensed Practical Nurses	16,453	17,346	314,732	18.14	4
5	CNAs & Orderlies	37,352	38,439	384,543	10.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,022	2,167	31,550	14.56	9
10	Activity Assistants	1,755	1,856	15,855	8.54	10
11	Social Service Workers	3,517	3,828	45,595	11.91	11
12	Dietician					12
13	Food Service Supervisor	2,296	2,456	35,294	14.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,246	5,626	57,990	10.31	15
16	Dishwashers	9,299	9,649	86,286	8.94	16
17	Maintenance Workers	1,671	1,695	24,434	14.42	17
18	Housekeepers	7,433	8,071	85,190	10.56	18
19	Laundry	6,091	6,434	61,593	9.57	19
20	Administrator	2,032	2,080	66,442	31.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,768	1,808	24,393	13.49	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	1,250	1,376	14,426	10.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,661	112,767	\$ 1,490,326 *	\$ 13.22	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	95	\$ 3,272	1.3	35
36	Medical Director	44	6,500	9.3	36
37	Medical Records Consultant	47	2,350	10.3	37
38	Nurse Consultant		300	10.3	38
39	Pharmacist Consultant	52	4,265	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	9	639	11.3	44
45	Social Service Consultant	9	639	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 17,965		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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number MAR KA NURSING HOME

# 0031740

Report Period Beginning:

10/1/14

Ending: 9/30/15

**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 \$4,499
- (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? N/A
- (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. \$ 1,764 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. N/A
- (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. \$ 151,956  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.