

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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>10/1/16</u> to <u>9/30/17</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) <u>PRESIDENT</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) <u>CAMILLE B. LOCKHART, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u> </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) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>CAMILLE B. LOCKHART, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>
<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) <u>PRESIDENT</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>CAMILLE B. LOCKHART, CPA</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>							

Facility Name & ID Number MAR-KA NURSING HOME

0031740 Report Period Beginning: 10/1/16 Ending: 9/30/17

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,121	9,619	2,031	16,771	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,121	9,619	2,031	16,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.46%

D. How many bed reserve days during this year were paid by the Department?
NONE (Do not include bed reserve 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 1,204

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/17 Fiscal Year: 9/30/17

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

Facility Name & ID Number **MAR-KA NURSING HOME** # **0031740** Report Period Beginning: **10/1/16** Ending: **9/30/17**

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	182,058	9,838	3,468	195,364		195,364		195,364		1
2	Food Purchase		97,092		97,092		97,092	(479)	96,613		2
3	Housekeeping	99,146	13,805		112,951		112,951	156	113,107		3
4	Laundry	51,446	9,837		61,283		61,283		61,283		4
5	Heat and Other Utilities			59,450	59,450		59,450		59,450		5
6	Maintenance	39,204	19,102	43,706	102,012		102,012	79	102,091		6
7	Other (specify):*										7
8	TOTAL General Services	371,854	149,674	106,624	628,152		628,152	(244)	627,908		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,113,167	76,351	5,806	1,195,324		1,195,324	10,677	1,206,001		10
10a	Therapy		684	114,614	115,298		115,298		115,298		10a
11	Activities	35,236	5,580	6,099	46,915		46,915		46,915		11
12	Social Services	50,873		573	51,446		51,446		51,446		12
13	CNA Training										13
14	Program Transportation			1,650	1,650		1,650		1,650		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,199,276	82,615	140,742	1,422,633		1,422,633	10,677	1,433,310		16
	C. General Administration										
17	Administrative	66,334			66,334		66,334	9,982	76,316		17
18	Directors Fees			2,400	2,400		2,400		2,400		18
19	Professional Services			175,163	175,163		175,163	(128,129)	47,034		19
20	Dues, Fees, Subscriptions & Promotions			48,596	48,596		48,596	(15,810)	32,786		20
21	Clerical & General Office Expenses	34,244	10,446	72,911	117,601		117,601	3,688	121,289		21
22	Employee Benefits & Payroll Taxes			207,627	207,627		207,627	7,120	214,747		22
23	Inservice Training & Education			1,634	1,634		1,634		1,634		23
24	Travel and Seminar			55	55		55	1,449	1,504		24
25	Other Admin. Staff Transportation							415	415		25
26	Insurance-Prop.Liab.Malpractice			16,327	16,327		16,327	35	16,362		26
27	Other (specify):*										27
28	TOTAL General Administration	100,578	10,446	524,713	635,737		635,737	(121,250)	514,487		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,671,708	242,735	772,079	2,686,522		2,686,522	(110,817)	2,575,705		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:

10/1/16

Ending:

9/30/17

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			21,001	21,001		21,001		21,001			30
31	Amortization of Pre-Op. & Org.							41	41			31
32	Interest			1,528	1,528		1,528	16,899	18,427			32
33	Real Estate Taxes			58,041	58,041		58,041		58,041			33
34	Rent-Facility & Grounds			18,000	18,000		18,000	(11,610)	6,390			34
35	Rent-Equipment & Vehicles			1,554	1,554		1,554	1,086	2,640			35
36	Other (specify):*											36
37	TOTAL Ownership			100,124	100,124		100,124	6,416	106,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		136,572		136,572		136,572		136,572			39
40	Barber and Beauty Shops		13		13		13		13			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,102	136,102		136,102		136,102			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		136,585	136,102	272,687		272,687		272,687			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,671,708	379,320	1,008,305	3,059,333		3,059,333	(104,401)	2,954,932			45

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

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		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	(2,825)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(479)	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	(32,999)	21		18
19	Entertainment				19
20	Contributions		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	(15,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(120)	20		28
29	Other-Attach Schedule	(17,538)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,779)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34,622)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (34,622)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (104,401)		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			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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MAR-KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/16

Ending: 9/30/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	NONALLOWABLE IHCA DUES	\$	(1,626)	21 1
2	MISCELLANEOUS INCOME		(15,912)	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
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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		(17,538)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

10/1/16

Ending:

9/30/17

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(479)	0	0	0	0	0	0	0	0	0	0	(479)	2
3	Housekeeping	0	0	156	0	0	0	0	0	0	0	0	156	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	79	0	0	0	0	0	0	0	0	79	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(479)	0	235	0	(244)	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	10,677	0	0	0	0	0	0	0	0	10,677	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	10,677	0	10,677	16							
	C. General Administration													
17	Administrative	0	0	9,982	0	0	0	0	0	0	0	0	9,982	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(128,129)	0	0	0	0	0	0	0	0	(128,129)	19
20	Fees, Subscriptions & Promotions	(15,938)	0	128	0	0	0	0	0	0	0	0	(15,810)	20
21	Clerical & General Office Expenses	(50,537)	0	54,225	0	0	0	0	0	0	0	0	3,688	21
22	Employee Benefits & Payroll Taxes	0	0	7,120	0	0	0	0	0	0	0	0	7,120	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,449	0	0	0	0	0	0	0	0	1,449	24
25	Other Admin. Staff Transportation	0	0	415	0	0	0	0	0	0	0	0	415	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	(66,475)	0	(54,775)	0	(121,250)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,954)	0	(43,863)	0	(110,817)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

10/1/16

Ending:

9/30/17

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	41	0	0	0	0	0	0	0	0	0	41	31
32	Interest	(2,825)	19,724	0	0	0	0	0	0	0	0	0	16,899	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(18,000)	6,390	0	0	0	0	0	0	0	0	(11,610)	34
35	Rent-Equipment & Vehicles	0	0	1,086	0	0	0	0	0	0	0	0	1,086	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,825)	1,765	7,476	0	6,416	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,779)	1,765	(36,387)	0	(104,401)	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	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	\$ 18,000	JAMES J. GIARDINA	100.00%	\$	(18,000)	1
2	V	32 INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	19,724	19,724	2
3	V	31 AMORTIZATION		JAMES J. GIARDINA	100.00%	41	41	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V	26 LIABILITY INS	9,950	RISA	25.00%	9,950		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 27,950			\$ 29,715	\$ * 1,765	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	6,390	6,390
17	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,086	1,086
18	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,982	9,982
19	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,677	10,677
20	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	54,225	54,225
21	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,120	7,120
22	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,471	1,471
23	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,449	1,449
24	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	415	415
25	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	79	79
26	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	128	128
27	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	35	35
28	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	156	156
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 129,600			\$ 93,213	\$ * (36,387)

* 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: 10/1/16

Ending: 9/30/17

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	Total		\$			\$	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	Total		\$			\$	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	Total		\$			\$	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	Total		\$			\$	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: 10/1/16

Ending: 9/30/17

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	Total		\$			\$	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: 10/1/16

Ending: 9/30/17

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	Total		\$			\$	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	Total		\$			\$	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	Total		\$			\$	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:

10/1/16

Ending:

9/30/17

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	\$ 7,877	17.7	1
2	MARY SCHAPER	SECRETARY			NONE	2	5.00	SALARY	2,105	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	\$ 9,982		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:

10/1/16

Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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				\$	\$	5,531,326	\$ 319,537	1
2	ST GENEVIEVE CARE CTR						3,169,059	97,380	2
3	CCC OF LEMAY						3,046,408	89,515	3
4	SALEM CARE CENTER						1,999,878	61,409	4
5	MONMOUTH NH						2,736,463	77,699	5
6	MAR-KA NH						2,929,733	93,213	6
7	CCC OF SENECA						3,316,587	95,759	7
8	MT VERNON PLACE CARE						2,812,326	77,745	8
9	COUNTRY VIEW NH						2,264,521	64,225	9
10	MERAMEC NH						3,198,319	93,314	10
11	SEVILLE CARE CENTER						3,343,167	97,719	11
12	SALEM RES CARE						616,000	25,734	12
13	CARL JUNCTION RES CARE						702,842	28,135	13
14	MT VERNON RES CARE						468,962	21,669	14
15	SENECA HOME PLACE						342,677	18,173	15
16	HUDSON HOUSE						667,073	27,141	16
17	MAPLE GROVE LODGE						3,351,069	94,687	17
18	CCC OF AURORA						4,620,953	128,967	18
19	BARRY COMMUNITY CARE						3,065,538	91,266	19
20	LICKING RESIDENTIAL CTR						388,318	19,436	20
21	CCC OF GAINESVILLE						3,212,048	90,419	21
22	AL OF SILVER CREEK						928,816	34,377	22
23	MARK TWAIN MANOR						6,265,445	176,453	23
24	CCC OF LICKING						2,136,110	60,675	24
25	TOTALS				\$	\$		\$ 1,984,647	25

Facility Name & ID Number MAR-KA NURSING HOME

0031740

Report Period Beginning:

10/1/16

Ending: 9/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization COMMUNITY CARE CENTERS, INC.
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

1	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				\$	\$	999,199	\$ 28,847	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				\$	\$		\$ 28,847	25

Facility Name & ID Number MAR-KA NURSING HOME

0031740

Report Period Beginning:

10/1/16

Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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: 10/1/16 Ending: 9/30/17

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:

10/1/16

Ending: 9/30/17

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
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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:

10/1/16

Ending:

9/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	XEROX		X	COPIER LEASE	\$97.61	3/1/13	\$ 5,038	\$ 385	2/28/18	7.0000	\$ 68	1								
2	TCF EQUIP FINANCE		X	2017 FORD BUS	\$982.45	6/21/17	\$ 59,112	\$ 57,056	6/22/23	6.1000	\$ 891	2								
3												3								
4												4								
5												5								
Working Capital																				
6	MISC INTEREST										\$ 569	6								
7			X									7								
8												8								
9	TOTAL Facility Related				\$1,080.06		\$ 64,150	\$ 57,441			\$ 1,528	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 64,150	\$ 57,441			\$ 1,528	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 2016 report.		\$	39,600	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.)		\$	55,341	2
3. Under or (over) accrual (line 2 minus line 1).		\$	15,741	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	42,300	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.		\$	58,041	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	45,454	8	
	2013	46,532	9	
	2014	49,066	10	
	2015	52,209	11	
	2016	55,341	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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 () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

10/1/16 Ending:

9/30/17

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: FACILITY, 48,000, 1986, \$ 75,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 48,000, (blank), \$ 75,000, 3.

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	\$	\$	\$
5			1986	14,621		10			
6									
7									
8									
	Improvement Type**								
9	ROOF REPAIR		1989	4,686		10			4,686
10	PATIO AND RAMP		1991	3,252		12			3,252
11	PATIO ROOF		1991	2,890		10			2,890
12	FLAT ROOF		1991	14,000		10			14,000
13	ROOF (NORTH WING)		1992	10,000		10			10,000
14	ROOF REPAIR		1990	7,055		10			7,055
15	SIDING REPAIR		1990	4,276		10			4,276
16	SPRINKLER SYSTEM		1993	2,168		25			2,168
17	BULLOCK GARAGES		1993	7,176		15			7,176
18	5 TON REFRIGERATION UNIT		1995	3,814		10			3,814
19	ROOF REPAIR		1995	18,785		10			18,785
20	LANDSCAPING - PATIO		1995	3,342		10			3,342
21	ROOFING REPAIR		1997	12,732		10			12,732
22	AIR CONDITIONING		1997	3,760		10			3,760
23	PHONE SYSTEM		1998	3,780		10			3,780
24	ELECTRICAL WORK		1999	3,613		20			3,613
25	COUNTERTOPS		1999	2,127		20			2,127
26	LENNOX 7.5 ROOFTOP UNIT		2000	5,733		10			5,733
27	ROOF ON EAST ASH WING		2000	6,400		10			6,400
28	MECHANICAL ROOM IMPR		2001	23,797		15			23,797
29	FIRE DAMPERS IN DUCT WORK		2001	1,900		15			1,900
30	FIRE DAMPERS IN DUCT WORK		2001	3,059		15			3,059
31	EXTERIOR KITCHEN DOORS		2002	1,567		20			1,567
32	RE-PLATE DOORS		2002	9,398		10			9,398
33									
34									
35									
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:

10/1/16

Ending:

9/30/17

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		Lease Life			142,937	62
63	NEW FIRE ALARM PANEL	2012	4,549		Lease Life			4,549	63
64	NEW DOOR FOR MED ROOM	2013	1,038		Lease Life			1,038	64
65	ROOFTOP A/C UNIT	2014	7,172	2,099	Lease Life	2,099		6,822	65
66	65GAL WATER HEATHER KITCHEN	2015	9,930	3,405	Lease Life	3,405		9,363	66
67	5-TON ROOFTOP A/C UNIT 3 PH 208/230V	2015	7,800	3,120	Lease Life	3,120		7,280	67
68	HEAT EXCHANGER SW ROOFTOP UNIT	2017	2,360	1,887		1,887		1,887	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	70

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

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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:

10/1/16

Ending:

9/30/17

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688

**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:

10/1/16

Ending:

9/30/17

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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:

10/1/16

Ending:

9/30/17

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688
2							
3							
4							
5							
6							
7							
8							
9							
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22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688

**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:

10/1/16

Ending:

9/30/17

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	34

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

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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
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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	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	34

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

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688

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

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		\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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	TOTAL (lines 1 thru 33)	\$ 1,425,219	\$ 10,511		\$ 10,511	\$	\$ 458,688	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:

10/1/16

Ending:

9/30/17

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	\$ 206,411	\$ 6,263	\$ 6,263	\$		\$ 179,674	71
72	Current Year Purchases	4,344	251	251			251	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 210,755	\$ 6,514	\$ 6,514	\$		\$ 179,925	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		2017 Ford Coach Bus	2017	63,614	3,976	3,976		4	3,976	78
79										79
80	TOTALS			\$ 96,899	\$ 3,976	\$ 3,976	\$		\$ 37,261	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)	\$ 1,807,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,001	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,001	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)	\$ 675,874	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: 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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 1,554 Description: STORAGE \$1,554

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			4 Total
		1 Drop-outs	2 Completed	3 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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10.a2&3	hrs	\$	683	\$ 43,798	\$ 575	683	\$ 44,373	1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		316	19,834		316	19,834	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.a2&3	hrs		770	50,982	109	770	51,091	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				120,375		120,375	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): Lab & X-ray	39.02					16,197		16,197	13
14	TOTAL			\$	1,769	\$ 114,614	\$ 137,256	1,769	\$ 251,870	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/17**

(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	\$ (25,655)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	640,564		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,000		5
6	Prepaid Insurance	3,179		6
7	Other Prepaid Expenses	16,660		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Mcr	14,150		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 649,898	\$	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	482,188		15
16	Equipment, at Historical Cost	307,654		16
17	Accumulated Depreciation (book methods)	(697,497)		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)	\$ 92,345	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 742,243	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,717,190	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,816		28
29	Short-Term Notes Payable	8,930		29
30	Accrued Salaries Payable	96,468		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,662		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To/From R/P; Unpaid Lease	1,793,540		36
37	Reserve A/R Litigation/Est. Ins. Liab.	(6,350)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,656,556	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	48,511		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)	\$ 48,511	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,705,067	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,962,824)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 742,243	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,162,078)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,162,078)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(534,828)	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)	\$ (534,828)	17
	B. Transfers (Itemize):		
18	PY ADJ BAD DEBTS	(265,918)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (265,918)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,962,824)	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,260,210	1
2	Discounts and Allowances for all Levels	(12,370,271)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,889,939	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	351,809	6
7	Oxygen	261,849	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 613,658	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	2,171	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,171	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,825	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,825	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	15,912	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,912	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,524,505	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	628,152	31
32	Health Care	1,422,633	32
33	General Administration	635,737	33
B. Capital Expense			
34	Ownership	100,124	34
C. Ancillary Expense			
35	Special Cost Centers	136,585	35
36	Provider Participation Fee	136,102	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,059,333	40
41	Income before Income Taxes (line 30 minus line 40)**	(534,828)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (534,828)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 667,202	44
45	Private Pay - Net Inpatient Revenue	1,307,134	45
46	Medicare - Net Inpatient Revenue	479,455	46
47	Other-(specify) HOSPICE	107,827	47
48	Other-(specify) PR YR C/A; PT A ANC; PART B C/A; BAD DEBTS	(671,679)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,889,939	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.

*** 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:

10/1/16

Ending:

9/30/17

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	2,080	2,080	\$ 62,480	\$ 30.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,498	10,974	265,218	24.17	3
4	Licensed Practical Nurses	12,999	13,919	267,637	19.23	4
5	CNAs & Orderlies	43,148	44,154	498,728	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,751	1,823	25,539	14.01	9
10	Activity Assistants	1,067	1,115	9,697	8.70	10
11	Social Service Workers	3,823	4,151	50,873	12.26	11
12	Dietician					12
13	Food Service Supervisor	2,296	2,624	40,351	15.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,436	6,787	67,370	9.93	15
16	Dishwashers	7,765	8,139	74,337	9.13	16
17	Maintenance Workers	1,994	2,083	39,204	18.82	17
18	Housekeepers	8,131	8,828	99,146	11.23	18
19	Laundry	4,993	5,379	51,446	9.56	19
20	Administrator	2,080	2,080	66,334	31.89	20
21	Assistant Administrator					21
22	Other Administrative	1,979	2,075	34,244	16.50	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,644	1,793	19,104	10.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,684	118,004	\$ 1,671,708 *	\$ 14.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	101	\$ 3,468	1.3	35
36	Medical Director	48	12,000	9.3	36
37	Medical Records Consultant	40	1,975	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	48	3,511	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	573	11.3	44
45	Social Service Consultant	8	573	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	253	\$ 22,100		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1	\$ 255	10.3	50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)	1	\$ 255		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
ALICE GREEN	ADMINISTRATOR		\$ 66,334	Workers' Compensation Insurance	\$ 28,683	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	23,970		
				FICA Taxes	142,182	Health Care Worker Background Check (Indicate # of checks performed 43)	487		
				Employee Health Insurance	30,160	Patient Background Checks			
				Employee Meals		DUES & SUBSCRIPTIONS	3,649		
				Illinois Municipal Retirement Fund (IMRF)*		TAXES & LICENSES	4,552		
				OTHER EMPLOYEE BENEFITS	5,599	ADVERTISING-OTHER	15,938		
				401K CONTRIBUTION	863	NONALLOWABLE IHCA DUES (In 21)			
				OSHA EMPLOYEE BENEFITS	140	HOME OFFICE ALLOCATION	128		
						Less: Public Relations Expense (
						Non-allowable advertising	(15,818)		
						Yellow page advertising	(120)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,334			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,786		
				HOME OFFICE ALLOCATION	7,120				
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 214,747				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	55	
							Seminar Expense		
							HOME OFFICE ALLOCATION	1,449	
							Entertainment Expense (
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,504	
C. Professional Services									
Vendor/Payee	Type		Amount						
COMMUNITY CARE CENTERS	MGT FEE		\$ 129,600						
SCHINDLER LAW FIRM	LEGAL		27,709						
RISK INSURANCE	LEGAL		8,389						
BKD, LLP	ACCOUNTING		9,465						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 175,163						

* Attach copy of IMRF notifications

**See instructions.

