FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0031740

Facility Name: MAR KA NURSING HOME

Address: 201 SOUTH 10TH ST (Number) MASCOUTAH (City) 62258 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 566-8000 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 12/23/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** (636) 394-3000
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/12 to 9/30/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) JAMES J. GIARDINA
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) CAMILLE LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,489	11,105	2,044	21,638	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,489	11,105	2,044	21,638	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.00%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 12/23/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 76 and days of care provided 1,691

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/13 Fiscal Year: 9/30/13

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 **Report Period Beginning:** 10/1/12 **Ending:** 9/30/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	175,139	16,023	2,997	194,159		194,159		194,159			1
2	Food Purchase		118,014		118,014		118,014	(415)	117,599			2
3	Housekeeping	68,381	14,117		82,498		82,498	137	82,635			3
4	Laundry	65,737	12,128		77,865		77,865		77,865			4
5	Heat and Other Utilities			62,350	62,350		62,350		62,350			5
6	Maintenance	34,677	23,908	27,930	86,515		86,515	629	87,144			6
7	Other (specify):*											7
8	**TOTAL General Services**	343,934	184,190	93,277	621,401		621,401	351	621,752			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	977,213	69,226	6,564	1,053,003		1,053,003	35,540	1,088,543			10
10a	Therapy		722	237,716	238,438		238,438		238,438			10a
11	Activities	48,788	7,867	2,510	59,165		59,165		59,165			11
12	Social Services	47,619	135	588	48,342		48,342		48,342			12
13	CNA Training											13
14	Program Transportation			2,135	2,135		2,135	(779)	1,356			14
15	Other (specify):* **Ambulance**			129	129		129		129			15
16	**TOTAL Health Care and Programs**	1,073,620	77,950	255,642	1,407,212		1,407,212	34,761	1,441,973			16
	C. General Administration											
17	Administrative	64,052			64,052		64,052	9,955	74,007			17
18	Directors Fees											18
19	Professional Services			33,900	33,900		33,900	(10,564)	23,336			19
20	Dues, Fees, Subscriptions & Promotions			42,746	42,746		42,746	(20,019)	22,727			20
21	Clerical & General Office Expenses	26,884	8,216	27,421	62,521		62,521	53,392	115,913			21
22	Employee Benefits & Payroll Taxes			227,352	227,352		227,352	10,094	237,446			22
23	Inservice Training & Education			886	886		886		886			23
24	Travel and Seminar			1,330	1,330		1,330	3,042	4,372			24
25	Other Admin. Staff Transportation							419	419			25
26	Insurance-Prop.Liab.Malpractice			39,371	39,371		39,371	41	39,412			26
27	Other (specify):* **Provision for Income Taxes**			30,631	30,631		30,631	(30,631)				27
28	**TOTAL General Administration**	90,936	8,216	403,637	502,789		502,789	15,729	518,518			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,508,490	270,356	752,556	2,531,402		2,531,402	50,841	2,582,243			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:** 10/1/12 **Ending:** 9/30/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,070	68,070		68,070		68,070			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest			8,307	8,307		8,307	(3,866)	4,441			32
33	Real Estate Taxes			40,954	40,954		40,954		40,954			33
34	Rent-Facility & Grounds			72,000	72,000		72,000	(66,313)	5,687			34
35	Rent-Equipment & Vehicles			1,560	1,560		1,560	2,336	3,896			35
36	Other (specify):*											36
37	**TOTAL Ownership**			190,891	190,891		190,891	(67,662)	123,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		133,508		133,508		133,508		133,508			39
40	Barber and Beauty Shops		115		115		115		115			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee		217,209		217,209		217,209		217,209			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		350,832		350,832		350,832		350,832			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,508,490	621,188	943,447	3,073,125		3,073,125	(16,821)	3,056,304			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: 10/1/12 Ending: 9/30/13

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(21,551)	32		10
11	Discounts, Allowances, Rebates & Refunds	(153)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(415)	2		13
14	Non-Care Related Interest	(4,008)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				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	(19,978)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(135)	20		28
29	Other-Attach Schedule	(33,451)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,691)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	62,870	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 62,870		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (16,821)		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 Yes	2 No	3 Amount	4 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

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/12

Ending: 9/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	$ (1,612)	21	1
2	MISCELLANEOUS INCOME	(429)	21	2
3	RESIDENT TRANSPORTATION	(779)	14	3
4	COMMISSION ON COLLECTIONS	0	21	4
5	PROVISION FOR INCOME TAXES	(30,631)	27	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,451)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME # 0031740 **Report Period Beginning:** 10/1/12 **Ending:** 9/30/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(415)	0	0	0	0	0	0	0	0	0	0	(415)	2
3	Housekeeping	0	0	137	0	0	0	0	0	0	0	0	137	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	629	0	0	0	0	0	0	0	0	629	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(415)	0	766	0	0	0	0	0	0	0	0	351	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	35,540	0	0	0	0	0	0	0	0	35,540	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	(779)	0	0	0	0	0	0	0	0	0	0	(779)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(779)	0	35,540	0	0	0	0	0	0	0	0	34,761	16
	C. General Administration													
17	Administrative	0	0	9,955	0	0	0	0	0	0	0	0	9,955	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(10,564)	0	0	0	0	0	0	0	0	(10,564)	19
20	Fees, Subscriptions & Promotions	(20,113)	0	94	0	0	0	0	0	0	0	0	(20,019)	20
21	Clerical & General Office Expenses	(2,194)	0	55,586	0	0	0	0	0	0	0	0	53,392	21
22	Employee Benefits & Payroll Taxes	0	0	10,094	0	0	0	0	0	0	0	0	10,094	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,042	0	0	0	0	0	0	0	0	3,042	24
25	Other Admin. Staff Transportation	0	0	419	0	0	0	0	0	0	0	0	419	25
26	Insurance-Prop.Liab.Malpractice	0	0	41	0	0	0	0	0	0	0	0	41	26
27	Other (specify):*	(30,631)	0	0	0	0	0	0	0	0	0	0	(30,631)	27
28	**TOTAL General Administration**	(52,938)	0	68,667	0	0	0	0	0	0	0	0	15,729	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,132)	0	104,973	0	0	0	0	0	0	0	0	50,841	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAR KA NURSING HOME # 0031740 **Report Period Beginning:** 10/1/12 **Ending:** 9/30/13

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

	Capital Expense D. Ownership	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)	
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	(25,559)	21,693	0	0	0	0	0	0	0	0	0	(3,866)	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)	5,687	0	0	0	0	0	0	0	0	(66,313)	34
35	Rent-Equipment & Vehicles	0	0	2,336	0	0	0	0	0	0	0	0	2,336	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,559)	(50,126)	8,023	0	0	0	0	0	0	0	0	(67,662)	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)**	(79,691)	(50,126)	112,996	0	0	0	0	0	0	0	0	(16,821)	45

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	BUILDING RENT	$ 72,000	JAMES J. GIARDINA	100.00%	$	$ (72,000)	1
2	V	32	INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	21,693	21,693	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	26	LIABILITY INS	33,250	RISA	25.00%	33,250		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 105,250			$ 55,124	$ * (50,126)	14

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	HOME OFFICE	$ 12,000	COMMUNITY CARE CENTERS, INC.	COMMON	$	$ (12,000)	15
16	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,687	5,687	16
17	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,336	2,336	17
18	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	35,540	35,540	18
19	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,955	9,955	19
20	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	55,586	55,586	20
21	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,094	10,094	21
22	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,436	1,436	22
23	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	3,042	3,042	23
24	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	419	419	24
25	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	629	629	25
26	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	94	94	26
27	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	41	41	27
28	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	137	137	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			$ 12,000			$ 124,996	$ * 112,996	39

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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: 10/1/12 Ending: 9/30/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	2	4.00	SALARY	$ 7,960	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,371	17.7	2
3	JESSICA CRANE	SECRETARY			NONE	2	5.00	SALARY	624	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,955		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: 10/1/12 Ending: 9/30/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		WEST COUNTY CARE CENTER				$	$	5,784,828	$ 194,691	1
2		ST GENEVIEVE CARE CTR						2,721,730	80,621	2
3		CCC OF LEMAY						2,758,746	85,741	3
4		SALEM CARE CENTER						2,018,561	61,294	4
5		MONMOUTH NH						2,904,949	82,106	5
6		MAR-KA NH						3,030,494	124,996	6
7		CCC OF SENECA						3,302,483	93,020	7
8		MT VERNON PLACE CARE						3,283,148	109,554	8
9		COUNTRY VIEW NH						2,549,564	87,057	9
10		MERAMEC NH						2,855,753	86,653	10
11		SEVILLE CARE CENTER						3,501,582	106,739	11
12		SALEM RES CARE						618,784	27,861	12
13		CARL JUNCTION RES CARE						727,464	30,844	13
14		MT VERNON RES CARE						492,776	24,399	14
15		SENECA HOME PLACE						470,064	23,778	15
16		HUDSON HOUSE						617,735	27,833	16
17		MAPLE GROVE LODGE						3,409,999	107,160	17
18		CCC OF AURORA						4,488,628	130,294	18
19		BARRY COMMUNITY CARE						3,166,164	123,429	19
20		LICKING RESIDENTIAL CTR						402,502	21,924	20
21		CCC OF GAINESVILLE						3,519,536	104,876	21
22		AL OF SILVER CREEK						788,475	33,711	22
23		MARK TWAIN MANOR						6,342,220	178,821	23
24		CCC OF LICKING						2,775,510	78,552	24
25	TOTALS					$	$		$ 2,025,954	25

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		COMMUNITY IN HOME				$	$	1,052,552	$ 28,896	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					$	$		$ 28,896	25

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	US BANK		X	2002 CHEVY VAN	$294.41	4/24/09	$ 14,000	$ 2,102	4/24/14	9.5600	$ 367	1
2	XEROX		X	COPIER LEASE	$97.61	3/1/13	5,038	4,451	3/1/18	6.0880	194	2
3												3
4												4
5												5
	Working Capital											
6	REGIONS BANK		X	LOC		12/19/11	2,887	225,000	12/17/13	3.5190	3,738	6
7	DUE TO SHAREHOLDER	X									4,008	7
8												8
9	TOTAL Facility Related				$392.02		$ 21,925	$ 231,553			$ 8,307	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 21,925	$ 231,553			$ 8,307	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 38,700	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.)		$ 45,454	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,754	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 34,200	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.		$ 40,954	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	46,529	8
	2009	48,840	9
	2010	49,565	10
	2011	51,219	11
	2012	45,454	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31.01-114-007	LOT/SEC-31-SUBL/TWP-1N-	$ 45,262.18	$ 45,262.18
2.		BLK/RG-6W PT LOT 12C	$	$
3.		DOC A01700220	$	$
4.	10-31.0-113-009	LOT/SEC-18 BK 2659-1974	$ 192.00	$ 192.00
5.	10-31.0-114-009	LOT/SEC-31-SUBL/TWP-1N-	$	$
6.		BLK/RG-6W BK 2659-1974	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,454.18	$ 45,454.18

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 10/1/12 Ending: 9/30/13

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 [X] (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 [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	FACILITY	48,000	1986	$ 75,000	1
2					2
3	TOTALS	48,000		$ 75,000	3

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1986	$ 950,000	$	22.5	$	$	$ 950,000	4
5				1986	14,621		10			14,621	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIR			1989	4,686		10			4,686	9
10	PATIO AND RAMP			1991	3,252		12			3,252	10
11	PATIO ROOF			1991	2,890		10			2,890	11
12	FLAT ROOF			1991	14,000		10			14,000	12
13	ROOF (NORTH WING)			1992	10,000		10			10,000	13
14	ROOF REPAIR			1990	7,055		10			7,055	14
15	SIDING REPAIR			1990	4,276		10			4,276	15
16	SPRINKLER SYSTEM			1993	2,168		25			2,168	16
17	BULLOCK GARAGES			1993	7,176		15			7,176	17
18	5 TON REFRIGERATION UNIT			1995	3,814		10			3,814	18
19	ROOF REPAIR			1995	18,785		10			18,785	19
20	LANDSCAPING - PATIO			1995	3,342		10			3,342	20
21	ROOFING REPAIR			1997	12,732		10			12,732	21
22	AIR CONDITIONING			1997	3,760		10			3,760	22
23	PHONE SYSTEM			1998	3,780		10			3,780	23
24	ELECTRICAL WORK			1999	3,613		20			3,613	24
25	COUNTERTOPS			1999	2,127		20			2,127	25
26	LENNOX 7.5 ROOFTOP UNIT			2000	5,733		10			5,733	26
27	ROOF ON EAST ASH WING			2000	6,400		10			6,400	27
28	MECHANICAL ROOM IMPR			2001	23,797		15			23,797	28
29	FIRE DAMPERS IN DUCT WORK			2001	1,900		15			1,900	29
30	FIRE DAMPERS IN DUCT WORK			2001	3,059		15			3,059	30
31	EXTERIOR KITCHEN DOORS			2002	1,567		20			1,567	31
32	RE-PLATE DOORS			2002	9,398		10			9,398	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	
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	53,601	Lease Life	53,601		80,401	62
63	NEW FIRE ALARM PANEL	2012	4,549	1,706	Lease Life	1,706		2,559	63
64	NEW DOOR FOR MED ROOM	2013	1,038	346	Lease Life	346		346	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,397,957	$ 55,653		$ 55,653	$	$ 1,332,739	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: 10/1/12 Ending: 9/30/13

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	$ 198,636	$ 5,371	$ 5,371	$		$ 168,027	71
72	Current Year Purchases	9,638	845	845			845	72
73	Fully Depreciated Assets							73
74	Disposals	(6,794)						74
75	TOTALS	$ 201,480	$ 6,216	$ 6,216	$		$ 168,872	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	$ 2,967	$ 2,967	$	4	$ 20,346	76
77		New Engine for 2002 Chevy	2010	12,938	3,234	3,234		4	10,242	77
78										78
79										79
80	TOTALS			$ 33,285	$ 6,201	$ 6,201	$		$ 30,588	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)	$ 1,707,722	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,070	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)	$ 1,532,199	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.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 1,560 Description: STORAGE $1,560
    (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: 10/1/12 Ending: 9/30/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.2&3	hrs	$	1,067	$ 70,211	$	1,067	$ 70,211	1
2	Licensed Speech and Language Development Therapist	10a.2&3	hrs		473	34,240		473	34,240	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.2&3	hrs		1,807	133,265	722	1,807	133,987	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	3,347	$ 237,716	$ 722	3,347	$ 238,438	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.

STATE OF ILLINOIS

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 91,979	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	649,508		3
4	Supply Inventory (priced at)	1,350		4
5	Short-Term Investments	4,395		5
6	Prepaid Insurance	13,994		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due To/From R/P			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 761,226	$	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	450,622		15
16	Equipment, at Historical Cost	234,765		16
17	Accumulated Depreciation (book methods)	(584,866)		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)**	$ 100,521	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 861,747	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,252,609	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,216		28
29	Short-Term Notes Payable	7,474		29
30	Accrued Salaries Payable	94,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,699		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,200		32
33	Accrued Interest Payable	5,010		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Income Taxes Payable	30,631		36
37	Due To/From R/P; Due Mcr; Unpd Leases	1,266,202		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,711,963	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	224,079		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)**	$ 224,079	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,936,042	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,074,295)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 861,747	$	48

***(See instructions.)**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,164,500)	1
2	Restatements (describe):	(1)	2
3	Rounding		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,164,501)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	90,206	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)**	$ 90,206	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,074,295)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 18,394,720	1
2	Discounts and Allowances for all Levels	(16,168,997)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,225,723	3
	B. Ancillary Revenue		
4	Day Care	1,325	4
5	Other Care for Outpatients		5
6	Therapy	643,548	6
7	Oxygen	267,269	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 912,142	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	2,554	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,554	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,551	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,551	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RES TRANSP/MISC INCOME/AP TRADE DISCOUNTS	1,361	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,361	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,163,331	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	621,401	31
32	Health Care	1,407,212	32
33	General Administration	502,789	33
	B. Capital Expense		
34	Ownership	190,891	34
	C. Ancillary Expense		
35	Special Cost Centers	133,508	35
36	Provider Participation Fee	217,209	36
	D. Other Expenses (specify):		
37	Barber & Beauty	115	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,073,125	40
41	**Income before Income Taxes (line 30 minus line 40)****	90,206	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 90,206	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 860,098	44
45	Private Pay - Net Inpatient Revenue	1,287,049	45
46	Medicare - Net Inpatient Revenue	63,736	46
47	Other-(specify) Hospice	36,027	47
48	Other-(specify) Prior Yr C/A, Bad Debts	(21,187)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,225,723	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** TAX DEPRECIATION DIFFERENCE

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

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

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,080	$ 55,441	$ 26.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,775	8,290	191,968	23.16	3
4	Licensed Practical Nurses	15,709	16,549	299,251	18.08	4
5	CNAs & Orderlies	40,394	42,125	416,183	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	2,202	30,331	13.77	9
10	Activity Assistants	1,978	2,114	18,457	8.73	10
11	Social Service Workers	3,829	4,077	47,619	11.68	11
12	Dietician					12
13	Food Service Supervisor	2,098	2,306	31,135	13.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,561	5,976	57,968	9.70	15
16	Dishwashers	8,682	9,279	86,036	9.27	16
17	Maintenance Workers	2,057	2,129	34,677	16.29	17
18	Housekeepers	5,902	6,560	68,381	10.42	18
19	Laundry	7,087	7,291	65,737	9.02	19
20	Administrator	2,000	2,080	64,052	30.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,042	2,130	26,884	12.62	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	1,352	1,454	14,370	9.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,348	116,642	$ 1,508,490 *	$ 12.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	86	$ 2,997	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	46	2,081	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	48	4,355	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	610	11.3	44
45	Social Service Consultant	9	588	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	$ 16,631		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1	$ 70	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1	$ 70		53

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ALICE GREEN	ADMINISTRATOR		$ 64,052
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 64,052

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE CENTERS	MGT FEE	$ 12,000
SCHINDLER LAW FIRM	LEGAL	3,056
CCC-BRADLEY ARANT BOULT C	LEGAL	335
ELVIDGE KELLEY	LEGAL	2,695
ROSENBLUM, GOLDENHERSH	LEGAL	32
ADMIN-ST CLAIR CO SMALL CL	LEGAL	161
R ELLIOTT	LEGAL	1,606
CCC INC	LEGAL	150
MPRO MICHIGAN PEER REVIEV	LEGAL	4,190
BKD, LLP	ACCOUNTING	9,675
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 33,900

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,242
Unemployment Compensation Insurance	
FICA Taxes	146,787
Employee Health Insurance	24,951
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	5,517
401K CONTRIBUTION	855
HOME OFFICE ALLOCATION	10,094
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,446

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,852
Health Care Worker Background Check (Indicate # of checks performed 88)	952
Patient Background Checks	
DUES & SUBSCRIPTIONS	2,860
TAXES & LICENSES	3,969
ADVERTISING-OTHER	20,113
NONALLOWABLE IHCA DUES(ln 21)	0
HOME OFFICE ALLOCATION	94
Less: Public Relations Expense	( )
Non-allowable advertising	(19,978)
Yellow page advertising	(135)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,727

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,330
Seminar Expense	
HOME OFFICE ALLOCATION	3,042
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,372

**See instructions.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/12 Ending: 9/30/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $4,195**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,993** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **217,209**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
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? **62%**
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 out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.