

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0031740</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>MAR KA NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/11</u> to <u>9/30/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>201 SOUTH 10TH STREET</u> <u>MASCOUTAH</u> <u>62258</u>																									
Number City Zip Code																									
County: <u>ST. CLAIR</u>																									
Telephone Number: <u>(618) 566-8000</u> Fax # <u>()</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>JAMES J. GIARDINA</u></td></tr><tr><td>(Title) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>JAMES J. GIARDINA</u>	(Title) _____	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>												
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	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>																								
Date of Initial License for Current Owners: <u>12/23/86</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>YVONNE CHUA</u> Telephone Number: <u>(636) 394-3000</u> Email Address: _____																									

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	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	<u>76</u>	TOTALS	<u>76</u>	<u>27,816</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,432</u>	<u>7,920</u>	<u>1,401</u>	<u>18,753</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,432</u>	<u>7,920</u>	<u>1,401</u>	<u>18,753</u>	14

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

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. 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 12/23/86NO ☐

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 1,068Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 9/30/12Fiscal Year: 9/30/12

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

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

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

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

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

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(229)	30		9
10	Interest and Other Investment Income	(2,689)	32		10
11	Discounts, Allowances, Rebates & Refunds	(38)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	2		13
14	Non-Care Related Interest	(1,002)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,517)	21		18
19	Entertainment				19
20	Contributions	(85)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,639)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(135)	20		28
29	Other-Attach Schedule	(2,630)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,337)		\$	30

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)	(217,467)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,467)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (250,804)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 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		9,681	10.2	42
43	Prescription Drugs	X		92,643	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 102,324		47

STATE OF ILLINOIS
MAR KA NURSING HOME

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	NONALLOWABLE IHCA DUES	\$ (1,542)	20	1
2	MISCELLANEOUS INCOME	(171)	21	2
3	RESIDENT TRANSPORTATION	(917)	14	3
4	COMMISSION ON COLLECTIONS		21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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18				18
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37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,630)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME

0031740

Report Period Beginning:

10/1/11

Ending:

9/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(373)	0	0	0	0	0	0	0	0	0	0	(373)	2
3	Housekeeping	0	0	131	0	0	0	0	0	0	0	0	131	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	131	0	0	0	0	0	0	0	0	131	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(373)	0	262	0	0	0	0	0	0	0	0	(111)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	19,728	0	0	0	0	0	0	0	0	19,728	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(917)	0	0	0	0	0	0	0	0	0	0	(917)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(917)	0	19,728	0	0	0	0	0	0	0	0	18,811	16
	C. General Administration													
17	Administrative	0	0	9,236	0	0	0	0	0	0	0	0	9,236	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(87,103)	0	0	0	0	0	0	0	0	(87,103)	19
20	Fees, Subscriptions & Promotions	(22,316)	0	70	0	0	0	0	0	0	0	0	(22,246)	20
21	Clerical & General Office Expenses	(5,811)	0	47,680	0	0	0	0	0	0	0	0	41,869	21
22	Employee Benefits & Payroll Taxes	0	0	10,291	0	0	0	0	0	0	0	0	10,291	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,778	0	0	0	0	0	0	0	0	3,778	24
25	Other Admin. Staff Transportation	0	0	350	0	0	0	0	0	0	0	0	350	25
26	Insurance-Prop.Liab.Malpractice	0	0	35	0	0	0	0	0	0	0	0	35	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(28,127)	0	(15,663)	0	0	0	0	0	0	0	0	(43,790)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,417)	0	4,327	0	0	0	0	0	0	0	0	(25,090)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(229)	0	0	0	0	0	0	0	0	0	0	(229)	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(3,691)	22,050	0	0	0	0	0	0	0	0	0	18,359	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(250,800)	5,606	0	0	0	0	0	0	0	0	(245,194)	34
35	Rent-Equipment & Vehicles	0	0	1,169	0	0	0	0	0	0	0	0	1,169	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,920)	(228,569)	6,775	0	0	0	0	0	0	0	0	(225,714)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,337)	(228,569)	11,102	0	0	0	0	0	0	0	0	(250,804)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J. GIARDINA	100	MONMOUTH NURSING HOME	MONMOUTH	COMMUNITY	BALLWIN, MO	HOME OFFICE
		BARRY COMMUNITY CARE CENTER	BARRY	CARE CENTERS		
				RISA	JEFFERSON CITY, MO	W/C INS
				RISA	JEFFERSON CITY, MO	LIAB INS

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	BUILDING RENT	\$ 250,800	JAMES J. GIARDINA	100.00%	\$	(250,800)	1
2	V	32	INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	22,050	22,050	2
3	V	30	DEPRECIATION		JAMES J. GIARDINA	100.00%			3
4	V	31	AMORTIZATION		JAMES J. GIARDINA	100.00%	181	181	4
5	V								5
6	V								6
7	V								7
8	V	22	WORKERS COMP INS	35,230	RISA	25.00%	35,230		8
9	V	26	LIABILITY INS	30,400	RISA	25.00%	30,400		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 316,430			\$ 87,861	\$ * (228,569)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	HOME OFFICE	\$ 88,800	COMMUNITY CARE CENTERS, INC.	COMMON	\$	\$ (88,800)	15
16	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,606	5,606	16
17	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,169	1,169	17
18	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	19,728	19,728	18
19	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,236	9,236	19
20	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	47,680	47,680	20
21	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,291	10,291	21
22	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,697	1,697	22
23	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	3,778	3,778	23
24	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	350	350	24
25	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131	25
26	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	70	70	26
27	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	35	35	27
28	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 88,800			\$ 99,902	\$ * 11,102	39

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

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	2	4.00	SALARY	\$ 7,599	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,637	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,236		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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				\$	\$	1,035,825	\$ 27,477	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 27,477	25

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	US BANK		X	2002 CHEVY VAN	\$294.41	4/24/09	\$ 14,000	\$ 5,268	4/24/14	9.5600	\$ 655	1		
2	REGIONS BANK		X	SPRINKLER SYSTEM		12/19/11	142,000		6/30/12	3.5388	2,034	2		
3												3		
4												4		
5												5		
	Working Capital													
6	REGIONS BANK		X	LOC		12/19/11	2,887	410,000	12/17/12	3.5190		6		
7	DUE TO SHAREHOLDER										1,002	7		
8												8		
9	TOTAL Facility Related				\$294.41		\$ 158,887	\$ 415,268			\$ 3,691	9		
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 158,887	\$ 415,268			\$ 3,691	15		

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2011 report.			\$	37,350	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	51,219	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$	13,869	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	38,700	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	52,569	7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2007	37,534	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2008	46,529	9																					
		2009	48,840	10																					
		2010	49,565	11																					
		2011	51,219	12																					

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
MAR KA NURSING HOME

COUNTY
ST. CLAIR

FACILITY IDPH LICENSE NUMBER
0031740

CONTACT PERSON REGARDING THIS REPORT
YVONNE CHUA

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

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,425

B. General Construction Type: Exterior BRICK

Frame STEEL REINFORCE

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	48,000	1986	\$ 75,000	1
2					2
3	TOTALS	48,000		\$ 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	\$	\$	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

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	238	Lease Life	238		3,922	55
56	FLAT ROOF	2009	18,669	1,167	Lease Life	1,167		18,669	56
57	ALUMINUM COATING ROOF	2009	2,775	268	Lease Life	268		2,775	57
58	BOILER MOTOR & LOUVER (\$1,594 desk audit adj 2012)	2010		123			(123)		58
59	GARAGE ROOF (\$1,007 desk audit adj 2012)	2010		106			(106)		59
60	2 FIRE RATED DOORS	2011	4,756	951	Lease Life	951		4,756	60
61	OFFICE A/C 9000 BTU	2011	3,438	1,146	Lease Life	1,146		3,438	61
62	NEW SPRINKLER SYSTEM	2012	142,937	26,800	Lease Life	26,800		26,800	62
63	NEW FIRE ALARM PANEL	2012	4,549	853	Lease Life	853		853	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,396,919	\$ 31,652		\$ 31,423	\$ (229)	\$ 1,277,086	70

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

XI. OWNERSHIP COSTS (continued)

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

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

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2002 Chevy Express Van	2009	\$20,346	\$5,087	\$5,087	\$	4	\$17,379	76
77		New Engine for 2002 Chevy	2010	12,938	3,234	3,234		4	7,008	77
78										78
79										79
80	TOTALS			\$33,284	\$8,321	\$8,321	\$		\$24,387	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,703,83981
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$45,94182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$45,71283**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(229)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,470,92285

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		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:

YESNO

 Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$2,566

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.2&3	hrs	\$	685	\$ 49,241	\$ 196	685	\$ 49,437	1
2	Licensed Speech and Language Development Therapist	10a.2&3	hrs		120	8,135		120	8,135	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.2&3	hrs		979	72,204	388	979	72,592	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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			\$	1,784	\$ 129,580	\$ 584	1,784	\$ 130,164	14

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

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	\$ 17,765	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	595,527		3
4	Supply Inventory (priced at)	1,350		4
5	Short-Term Investments	3,123		5
6	Prepaid Insurance	12,813		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due To/From R/P	(834,831)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (204,253)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	449,584		15
16	Equipment, at Historical Cost	231,921		16
17	Accumulated Depreciation (book methods)	(523,588)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 157,917	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (46,336)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 980,773	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,466		28
29	Short-Term Notes Payable	3,175		29
30	Accrued Salaries Payable	87,824		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,392		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,700		32
33	Accrued Interest Payable	1,002		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To/From Related Parties	339,925		36
37	Est insurance liab	233,814		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,706,071	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	412,093		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 412,093	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,118,164	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,164,500)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (46,336)	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,680,234)	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT-BAD DEBTS/AR	(5,913)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,686,147)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(478,353)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (478,353)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,164,500)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,940,050	1
2	Discounts and Allowances for all Levels	(14,009,024)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,931,026	3
B. Ancillary Revenue			
4	Day Care	5,155	4
5	Other Care for Outpatients		5
6	Therapy	325,185	6
7	Oxygen	196,380	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 526,720	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,091	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,091	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,275	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,275	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RES TRANSP/MISC INCOME/AP TRADE DISCOUNT	1,126	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,126	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,462,238	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	586,493	31
32	Health Care	1,306,266	32
33	General Administration	547,599	33
B. Capital Expense			
34	Ownership	355,567	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	144,666	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,940,591	40
41	Income before Income Taxes (line 30 minus line 40)**	(478,353)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (478,353)	43

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

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX DEPRECIATION DIFFERENCE
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,080	\$ 53,896	\$ 25.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,348	6,636	151,765	22.87	3
4	Licensed Practical Nurses	16,105	16,877	298,635	17.69	4
5	CNAs & Orderlies	37,639	39,233	382,891	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,888	2,024	26,857	13.27	9
10	Activity Assistants	1,329	1,383	11,903	8.61	10
11	Social Service Workers	3,532	3,820	43,120	11.29	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,248	28,859	12.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,627	6,979	69,513	9.96	15
16	Dishwashers	7,540	7,939	74,613	9.40	16
17	Maintenance Workers	1,582	1,814	29,910	16.49	17
18	Housekeepers	7,052	7,602	75,486	9.93	18
19	Laundry	5,683	6,030	53,102	8.81	19
20	Administrator	2,008	2,080	62,402	30.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,738	1,826	22,649	12.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,333	1,405	13,453	9.58	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	104,556	109,976	\$ 1,399,054 *	\$ 12.72	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	90	\$ 3,127	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	46	2,070	10.3	37
38	Nurse Consultant	1	395	10.3	38
39	Pharmacist Consultant	48	4,339	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	561	11.3	44
45	Social Service Consultant	8	561	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	249	\$ 17,053		49

C. CONTRACT NURSES

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

XIX. 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		\$ 62,402	Workers' Compensation Insurance		\$ 52,042	IDPH License Fee	\$	
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	17,547	
				FICA Taxes		127,643	Health Care Worker Background Check	908	
				Employee Health Insurance		17,508	(Indicate # of checks performed 82)		
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			DUES & SUBSCRIPTIONS	4,516	
				OTHER EMPLOYEE BENEFITS		8,105	TAXES & LICENSES	1,801	
				401K CONTRIBUTION		873	ADVERTISING-OTHER	20,774	
TOTAL (agree to Schedule V, line 17, col. 1)							NONALLOWABLE IHCA DUES	(1,542)	
(List each licensed administrator separately.)							HOME OFFICE ALLOCATION	70	
B. Administrative - Other							Less: Public Relations Expense	()	
Description							Non-allowable advertising	(20,639)	
							Yellow page advertising	(135)	
							TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 23,300		
TOTAL (agree to Schedule V, line 17, col. 3)									
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
COMMUNITY CARE CENTERS	MGT FEE		\$ 88,800			\$	Out-of-State Travel	\$	
SCHINDLER LAW FIRM	LEGAL		3,918						
REEL LAW FIRM	LEGAL		955				In-State Travel	2,019	
ROSENBLUM, GOLDENHERSH	LEGAL		1,232						
WIMMER, STIEHL & MCCARTH	LEGAL		2,861						
CCC-BRADLEY ARANT BOULT C	LEGAL		3,900						
RISK INSURANCE SERVICES	LEGAL-LIAB DEDUCTIBLES		20,000				Seminar Expense		
BKD, LLP	ACCOUNTING		15,940				HOME OFFICE ALLOCATION	3,778	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL		
\$ 137,606							\$ 5,797		

*** Attach copy of IMRF notifications**

****See instructions.**

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

IL HEALTH CARE ASSOC \$4,195

(3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

3-10

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 3,027

Line 10.2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 144,666

This amount is to be recorded on line 42 of Schedule V.

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

(13)

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

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

YES

If YES, attach a complete explanation.

See Attached Schedule

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

72%

d.

Have vehicle usage logs been maintained?

YES

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.

HFS 3745 (N-4-99)

IL478-2471