

Ohio Department of Job and Family Services  
**MEDICAID NURSING FACILITY COST REPORT**

Type of Cost Report Filing. (Please check one of the following)

4.1 Year-End                       4.3 Change of Operator                       4.5 Final

4.2 New Facility                       4.6 Amended

**INSTRUCTIONS:** This cost report must be postmarked pursuant to Ohio Administrative Code. Failure to file timely will result in reduction of the current prospective rate by two dollars (\$2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with Ohio Revised Code. Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit a diskette or compact disk to Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414

Provider Name (DBA) <b>MORNING VIEW CARE CNTR MARION</b>	National Provider Identifier	Medicaid Provider Number <b>0001910</b>	Medicare Provider Number <b>36-5935</b>
Complete Facility Address Address(1) <b>677 W MARION CARDINGTON R</b> Address(2) <b>P O BOX 656</b> City <b>MARION</b> State of Ohio Zip Code <b>43302</b>	Federal Tax ID Number <b>34-1286757</b>	Period Covered by Cost Report	
	ODH ID Number <b>0885</b>	From	<b>01/01/2006</b>
	County <b>MARION</b>	Through	<b>12/31/2006</b>

TYPE OF CONTROL OF PROVIDER- (Please check one of the following):

<p><b>For Profit</b></p> <p><input type="checkbox"/> Sole Proprietorship (1.1)                      <input checked="" type="checkbox"/> Corporation (1.3)</p> <p><input type="checkbox"/> Partnership (1.2)                      <input type="checkbox"/> Limited Liability Company (1.5)</p> <p><input type="checkbox"/> 1. General                      <input type="checkbox"/> Business Trust (1.6)</p> <p><input type="checkbox"/> 2. Limited                      <input type="checkbox"/> Real Estate Investment Trust (REIT) (1.7)</p> <p><input type="checkbox"/> 3. Limited Liability Partnership                      <input type="checkbox"/> Other: Specify _____ (1.4)</p>	<p><b>PROVIDER LEGAL ENTITY IDENTIFICATION</b></p> <p>Name Of Legal Entity <b>DEARTH MANAGEMENT, INC</b></p> <p>Address(1) <b>134 NORTHWOODS BLVD</b></p> <p>Address(2) _____</p> <p>City <b>COLUMBUS</b> State <b>OH</b></p> <p>Zip Code <b>43235-4727</b></p>
	<p><b>NAME AND ADDRESS OF OWNER OF REAL ESTATE</b></p> <p>Name <b>DEARTH MANAGEMENT, INC</b></p> <p>Address(1) <b>134 NORTHWOODS BLVD</b></p> <p>Address(2) _____</p> <p>City <b>COLUMBUS</b> State <b>OH</b></p> <p>Zip Code <b>43235-4727</b></p>

**Location Of Entity, Organization, or Incorporation:**

If facility has a For Profit type of control, check one below:

Domestic (1.8)

Foreign (1.9) Location: \_\_\_\_\_

<p><b>Non-Profit</b></p> <p><input type="checkbox"/> Domestic Non-Profit Corporation (2.4)</p> <p><input type="checkbox"/> Foreign Non-Profit Corporation Location: _____ (2.5)</p> <p><input type="checkbox"/> Other (not yet defined "non profit" entity) Specify _____ (2.6)</p>	<p><b>CARE SETTING</b></p> <p>Check all that apply</p> <p><input type="checkbox"/> a. Rehab Hospital Based</p> <p><input type="checkbox"/> b. General/Acute Hospital Based</p> <p><input type="checkbox"/> c. Home For the Aging</p> <p><input type="checkbox"/> d. Continuing Care Retirement Center (CCRC)</p> <p><input type="checkbox"/> e. Other Assisted Living/Nursing Home Combination</p> <p><input type="checkbox"/> f. Religious Non-Medical Health Care Institution</p> <p><input type="checkbox"/> g. Free Standing</p> <p><input type="checkbox"/> h. Combined with ICF-MR and/or Outlier Unit</p> <p><input type="checkbox"/> i. Other: Specify: _____</p>
<p><b>Non-Federal Government</b></p> <p><input type="checkbox"/> State (3.1)                      <input type="checkbox"/> City-County (3.4)</p> <p><input type="checkbox"/> County (3.2)                      _____</p> <p><input type="checkbox"/> City (3.3)                      <input type="checkbox"/> Other (Specify Control): _____ (3.6)</p>	

ALL PATIENTS	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
1. Licensed beds at beginning of period	30.0	30.0
** 2. Licensed beds at end of period	30.0	30.0
3. Total bed days available	10,950.0	10,950.0
4. Total inpatient days	7,554.5	7,554.5
5. Percentage of occupancy (line 4 divided by line 3 X 100)	68.99	68.99
6. Ancillary/Support allowable days (greater of line 4 or .9 X line 3)	9,855.0	9,855.0

OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS	
7. Total patient days (from Schedule A-1, line 13, column 5)	6,655.5
8. Utilization Rate(line 7 divided by line 4, col. 1 X 100)	88.10

\*\* If line 2 is different from col. 1, line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

\*\* If line 2 is different from col. 1, line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

\*\* If line 2 is different from col. 1, line 1, note date of change \_\_\_\_\_ and number of beds involved \_\_\_\_\_

CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name <b>MORNING VIEW CARE CENTER OF MARION</b>	Medicaid Provider Number <b>0001910</b>	Reporting Period From <b>01/01/2006</b> Through <b>12/31/2006</b>
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CHAIN HOME OFFICE INFORMATION

This section is to be completed with information about the "HOME OFFICE" for those providers that are members of, or are joining, a chain organization

A. If this section does not apply check here

B. Chain Home Office Information  Change Effective Date

1 Name Of Home Office As reported To The IRS **MORNING VIEW CARE CENTER** Federal Tax ID Number **34-1286757**

2 Home Office Business Street Address Line 1 **134 NORTHWOODS BLVD**

Home Office Business Street Address Line 2

City **COLUMBUS** State **OH** Zip Code **43235-4727**

C Provider's Affiliation To The Chain Home Office  Change Effective Date

Check the appropriate box:

- |   |   |  |
|---|---|--|
| 1. <input type="checkbox"/> Joint venture / Partnership | 3. <input type="checkbox"/> Managed / Related       | 5. <input type="checkbox"/> Leased                 |
| 2. <input type="checkbox"/> Operated / Related          | 4. <input checked="" type="checkbox"/> Wholly Owned | 6. <input type="checkbox"/> Other (Specify): _____ |

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, REV. (10/05), all cost reports submitted to ODJFS will be certified as follows:

**MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.**

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) **MORNING VIEW CARE CENTER OF MARION**, Medicaid Provider Number **0001910** for the cost report period beginning **1/1/2006** and ending **12/31/2006** and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted

Signature of Owner, Officer, or Authorized Representative of Provider	Date of Signature	No Date On File
Print or Type Name of Owner, Officer, or Authorized Representative of Provider (Last) <b>SHEPHERD</b> (First) <b>TAMARA</b> (M.I.) <b>K</b>		
Title <b>VP FINANCE</b>	Telephone Number Area Code (614) 847-1070	Fax Number Area Code (614) 847-1393

Report Prepared by (Company) <b>MORNING VIEW CARE CENTER</b>
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Report Prepared by (Individual) (Last) <b>SHEPHERD</b> (First) <b>TAMARA</b> (M.I.) <b>K</b>	Title <b>VP FINANCE</b>
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Address <b>134 NORTHWOODS BLVD</b>
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City, State, Zip Code <b>COLUMBUS OH 43235</b>
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Telephone Number of Person Preparing Cost Report Area Code (614) 847-1070	Fax Number Area Code (614) 847-1393
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Location of Records or Probable Audit Site Address <b>MORNING VIEW CARE CENTER 134 NORTHWOODS BLVD</b>	Telephone Number for Audit Contact Person Area Code <b>(614) 847-1070</b>
City <b>COLUMBUS</b> State <b>OH</b>	County <b>FRANKLIN</b>
Zip Code <b>43235</b>	

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this \_\_\_\_\_ day of \_\_\_\_\_

20\_\_\_\_ at \_\_\_\_\_, county of \_\_\_\_\_, and state of \_\_\_\_\_

Signature of Notary
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## SUMMARY OF INPATIENT DAYS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2006 Through: 12/31/2006
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INSTRUCTIONS: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. Nursing Facilities must report each medically necessary leave day and limited absence as 50% of an inpatient day. Please refer the Ohio Administrative Code for details.

Month	Number of Medicaid Certified Beds (1)	Medicaid Patients				Non-Medicaid Patients			Total Inpatient Days (sum of cols. 5-8) (9)
		Authorized Days (2)	Hospital Leave Days (@50%) (3)	Therapeutic Leave Days (@50%) (4)	Total Medicaid Days (sum of cols. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January	30	534	10.0	1.0	545.0	63	52	0	660.0
2. February	30	488	2.5	1.0	491.5	56	45	0	592.5
3. March	30	558	5.0	0.0	563.0	69	41	0	673.0
4. April	30	520	6.5	1.0	527.5	60	64	0	651.5
5. May	30	558	0.0	0.0	558.0	62	3	0	623.0
6. June	30	557	0.0	0.5	557.5	40	0	0	597.5
7. July	30	608	0.0	0.5	608.5	31	9	0	648.5
8. August	30	619	0.0	0.5	619.5	31	0	0	650.5
9. September	30	553	3.0	0.5	556.5	30	13	0	599.5
10. October	30	557	1.5	0.5	559.0	31	46	0	636.0
11. November	30	539	0.0	0.5	539.5	32	46	0	617.5
12. December	30	524	6.0	0.0	530.0	50	25	0	605.0
13. TOTAL (sum of lines 1 through 12)		6,615	34.5	6.0	6,655.5	555	344	0	7,554.5
					Schedule A, page 1, line 7, column 2				Schedule A, page 1, line 4, column 1

## DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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INSTRUCTIONS: Enter gross charges for resident days reported in Schedule A-1 and Attachment 4. These gross charges must be reported from a uniform charge structure applicable to all residents.

Description (1)	Medicare Part B Primary Payer is		Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
	Medicaid (2)	Other (3)					
<b>SECTION A: REVENUES</b>							
1a. Medical Supplies Revenue	0	1,729	0	1,348	0	17,762	20,839
1b. Percent of Medical Supplies Revenue by Payer Source	0.00%	8.30%	0.00%	6.47%	0.00%	85.23%	100%
2a. Medical Minor Equipment Revenue	0	0	0	0	0	0	0
2b. Percent of Medical Minor Equipment Revenue by Payer Source	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3a. Enteral Feeding Revenue	1,564	0	0	0	0	0	1,564
3b. Percent of Enteral Feeding Revenue by Payer Source	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100%
<b>4. Total Revenue by Payer Source</b>	<b>1,564</b>	<b>1,729</b>	<b>0</b>	<b>1,348</b>	<b>0</b>	<b>17,762</b>	<b>22,403</b>

SECTION B: COSTS (1)	MEDICARE PART B OFFSET CALCULATIONS			
	Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)
5. Percentage of Medicare Part B charges where primary payer is Medicaid (from Schedule A-2, column 2, applicable line b)	0.00%	0.00%	100.00%	
6. Costs (from Schedule B-2, column 3, lines 15 and Schedule C, lines 36 and 10)	10,420	280	0	
7. Costs to be offset (line 5 times line 6). Offset costs in column 4 on the schedules and lines identified in line 6 above.	0	0	0	0

SECTION C: ANCILLARY/SUPPORT COSTS - OFFSET	
8. Ancillary/Support costs (Schedule C, Line 79, column 3 less Schedule C, lines 18, 24, 51, 52, 53 and 71, column 3)	346,512
9. Total costs (total of Schedule B-1 line 5, Schedule B-2, line 43, Schedule C, line 79, Schedule D, lines 12 and 18, column 3)	1,215,164
10. Ancillary/Support costs as a percent of total costs (line 8 divided by line 9)	0.2852
11. Costs offset (from line 7 column 5 above)	0
12. Ancillary/Support costs to be offset (line 10 times line 11) offset costs on Schedule C line 63 column 4	0

SUMMARY OF COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION		Medicaid Provider Number 0001910	Reporting Period From: 01/01/2006 Through 12/31/2006	
<b>REIMBURSABLE COSTS</b>	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	
<b>TAX COST CENTER</b>				
1. Tax Cost	B1 line 5 Col 7		7,694	
<b>DIRECT CARE COST CENTER</b>				
2. Direct Care Cost	B2 line 43 Col 7		583,505	
<b>ANCILLARY/SUPPORT COST CENTER</b>				
3. Ancillary/Support Cost	C line 79 Col 7		555,061	
<b>CAPITAL COST CENTER</b>				
4. Assets Acquired Group A	D line 12 Col 7	64,415		
5. Assets thru Change of Operator Group B	D line 18 Col 7	0		
6. <b>TOTAL Capital Cost (sum of lines 4 and 5) col 2</b>			64,415	
<b>7. TOTAL REIMBURSABLE COSTS (sum of lines 1, 2, 3 and 6) Col 3</b>			1,210,675	

RECONCILIATION OF COSTS

Schedule/ Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
8. B1/5	col 3 7,694	col 4 0	col 5 7,694	col 7 7,694
9. B2/43	col 3 583,505	col 4 0	col 5 583,505	col 7 583,505
10. C/108	col 3 704,512	col 4 -4,905	col 5 699,607	col 7 699,607
11. D/12	col 3 63,999	col 4 416	col 5 64,415	col 7 64,415
12. D/18	col 3 0	col 4 0	col 5 0	col 7 0
13. Totals	\$ 1,359,710 <sup>(A)</sup>	\$ -4,489 <sup>(B)</sup>	\$ 1,355,221	\$ 1,355,221
14. Less Non-Reimbursable from Schedule C, page 3, line 107			col 5 (144,546)	col 7 (144,546)
15. Total Reimbursable			\$ 1,210,675 <sup>(C)</sup>	\$ 1,210,675 <sup>(C)</sup>

(A) Agrees to Total Expenses per Working Trial Balance.

(B) Agrees to Attachment 2, line 21, Column 4, and Schedule A-2, lines 7 and 12, column 5.

(C) Agrees to Schedule A-3, line 7, Column 3.

NOTE: All cost data should be rounded to the nearest whole dollar.

## TAX COSTS

Schedule B-1

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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TAX COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
1. Real Estate Taxes	6060		5,844	5,844	0	5,844	1.0000	5,844
2. Personal Property Taxes	6070		778	778	0	778	1.0000	778
3. Franchise Tax (Attach FT 1120)	6080		0	0	0	0	1.0000	0
4. Commercial Activity Tax (CAT)	6085		1,072	1,072	0	1,072	1.0000	1,072
<b>5. TOTAL Tax Costs (sum of lines 1 through 4)</b>			7,694	7,694	0	7,694		7,694

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

4.1

Schedule B-2

1 of 2

**DIRECT CARE COSTS**

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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<b>DIRECT CARE COSTS</b>	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
<b>NURSING AND HABILITATION/REHABILITATION</b>								
1. Medical Director	6100	0	3,600	3,600	0	3,600	1.0000	3,600
2. Director of Nursing	6105	58,376	0	58,376	0	58,376	1.0000	58,376
3. RN Charge Nurse	6110	0	0	0	0	0	1.0000	0
4. LPN Charge Nurse	6115	0	0	0	0	0	1.0000	0
5. Registered Nurse	6120	101,920	0	101,920	0	101,920	1.0000	101,920
6. Licensed Practical Nurse	6125	117,596	0	117,596	0	117,596	1.0000	117,596
7. Nurse Aides	6130	178,357		178,357	0	178,357	1.0000	178,357
8. Habilitation Staff	6170	0	0	0	0	0	1.0000	0
9. Respiratory Therapist	6185	0	0	0	0	0	1.0000	0
10. Quality Assurance	6205	0	2,250	2,250	0	2,250	1.0000	2,250
11. Consulting and Management Fees-Direct	6210		0	0	0	0	1.0000	0
12. Other Direct Care - Specify below	6220	0	0	0	0	0	1.0000	0
13. Home Office Costs/Direct Care **	6230	0	0	0	0	0	1.0000	0
<b>14. TOTAL Nursing and Habilitation/ Rehabilitation (sum of lines 1 through 13)</b>		456,249	5,850	462,099	0	462,099		462,099
<b>MEDICAL, HABILITATION, AND UNIVERSAL PRECAUTION SUPPLIES</b>								
15. Medical Supplies - Medicare Billable	6301		10,420	10,420	0	10,420	1.0000	10,420
16. Medical Supplies - Medicare Non-Billable	6311		3,372	3,372	0	3,372	1.0000	3,372
17. Oxygen - Emergency stand-by	6321		0	0	0	0	1.0000	0
18. Habilitation Supplies	6330		525	525	0	525	1.0000	525
19. Universal Precaution Supplies	6340		2,848	2,848	0	2,848	1.0000	2,848
<b>20. TOTAL Medical, Habilitation, and Universal Precaution Supplies (sum of lines 15 through 19)</b>			17,165	17,165	0	17,165		17,165
<b>PURCHASED NURSING SERVICES</b>								
21. Registered Nurse - Purchased Nursing	6401		0	0	0	0	1.0000	0
22. Licensed Practical Nurse Purchased Nursing	6411		1,895	1,895	0	1,895	1.0000	1,895
23. Nurse Aides - Purchased Nursing	6421		11,627	11,627	0	11,627	1.0000	11,627
<b>24. TOTAL Purchased Nursing (sum of lines 21 through 23)</b>			13,522	13,522	0	13,522		13,522

Line 12 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 12, Columns 1 and 2		

\*\* Home office costs are to be entered on line 13 only. They are not be distributed to any other line on this schedule.

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

**DIRECT CARE COSTS**

Provider Name MORNING VIEW CARE CENTER OF MARION		Medicaid Provider Number 0001910		Reporting Period From: 1/1/2006 Through: 12/31/2006				
<b>DIRECT CARE COSTS</b>	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
<b>NURSE AIDE TRAINING</b>								
25. In-House Trainer Wages	6500	2,241	0	2,241	0	2,241	1.0000	2,241
26. Classroom Wages - Nurse Aides	6511	4,538		4,538	0	4,538	1.0000	4,538
27. Clinical Wages - Nurse Aides	6521	581		581	0	581	1.0000	581
28. Books and Supplies	6531		87	87	0	87	1.0000	87
29. Transportation	6541		0	0	0	0	1.0000	0
30. Tuition Payments	6551		0	0	0	0	1.0000	0
31. Tuition Reimbursement	6560		0	0	0	0	1.0000	0
32. Contractual Payments to Other NFs	6570		0	0	0	0	1.0000	0
33. Registration Fees/Application Fees	6580		673	673	0	673	1.0000	673
34. Employee Fringe Benefits	6590		509	509	0	509	1.0000	509
<b>35. TOTAL Nurse Aide Training (sum of lines 25 through 34)</b>		7,360	1,269	8,629	0	8,629		8,629
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOP. (No Purchased Nursing)</b>								
36. Payroll Taxes - Direct Care	6700		33,617	33,617	0	33,617	1.0000	33,617
37. Workers' Compensation - Direct Care	6710		17,656	17,656	0	17,656	1.0000	17,656
38. Employee Fringe Benefits - Direct Care	6720		29,256	29,256	0	29,256	1.0000	29,256
39. EAP Administrator - Direct Care	6730	0	0	0	0	0	1.0000	0
40. Self Funded Programs Admin. - Direct Care	6740	0	0	0	0	0	1.0000	0
41. Staff Development - Direct Care	6750	353	1,208	1,561	0	1,561	1.0000	1,561
<b>42. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 36 thru 41)</b>		353	81,737	82,090	0	82,090		82,090
<b>43. TOTAL REIMBURSABLE DIRECT CARE COST (sum of lines 14, 20, 24, 35, and 42)</b>		463,962	119,543	583,505	0	583,505		583,505

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

## ANCILLARY/SUPPORT COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION		Medicaid Provider Number 0001910		Reporting Period From: 1/1/2006 Through: 12/31/2006				
ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
<b>DIETARY COST</b>								
1. Dietitian	7000	12,680	0	12,680	0	12,680	1.0000	12,680
2. Food Service Supervisor	7005	22,709	0	22,709	0	22,709	1.0000	22,709
3. Dietary Personnel	7015	28,348	0	28,348	0	28,348	1.0000	28,348
4. Dietary Supplies and Expenses	7025		3,561	3,561	0	3,561	1.0000	3,561
5. Dietary Minor Equipment	7030		21	21	0	21	1.0000	21
6. Dietary Maintenance and Repair	7035		224	224	0	224	1.0000	224
7. Food In-Facility	7040		39,474	39,474	0	39,474	1.0000	39,474
8. Employee Meals	7045		0	0	0	0	1.0000	0
9. Contract Meals/Contract Meals Personnel	7050		0	0	0	0	1.0000	0
10. Enterals: Medicare Billable	7055		0	0	0	0	1.0000	0
11. Enterals: Medicare Non-Billable	7056		578	578	0	578	1.0000	578
12. Payroll Taxes - Dietary	7060		4,090	4,090	0	4,090	1.0000	4,090
13. Workers' Compensation - Dietary	7065		1,469	1,469	0	1,469	1.0000	1,469
14. Employee Fringe Benefits - Dietary	7070		38	38	0	38	1.0000	38
15. EAP Administrator - Dietary	7075	0	0	0	0	0	1.0000	0
16. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	1.0000	0
17. Staff Development - Dietary	7090	0	111	111	0	111	1.0000	111
<b>18. TOTAL Dietary (sum of lines 1 through 17)</b>		<b>63,737</b>	<b>49,566</b>	<b>113,303</b>	<b>0</b>	<b>113,303</b>		<b>113,303</b>
<b>MEDICAL RECORDS, PHARMACY &amp; SUPPLIES</b>								
19. Medical/Habilitation Records	7105	461	0	461	0	461	1.0000	461
20. Pharmaceutical Consultant	7110	0	0	0	0	0	1.0000	0
21. Incontinence Supplies	7115		2,310	2,310	0	2,310	1.0000	2,310
22. Personal Care - Supplies	7120		2,658	2,658	0	2,658	1.0000	2,658
23. Program Supplies	7125		1,167	1,167	0	1,167	1.0000	1,167
<b>24. TOTAL Medical records, Pharmacy, and Supplies (sum of lines 19 through 23)</b>		<b>461</b>	<b>6,135</b>	<b>6,596</b>	<b>0</b>	<b>6,596</b>		<b>6,596</b>
<b>ACTIVITIES, HABILITATION &amp; SOCIAL SERVICES</b>								
25. Activity Director	7201	21,708	0	21,708	0	21,708	1.0000	21,708
26. Activity Staff	7211	861	0	861	0	861	1.0000	861
27. Recreational Therapist	7221	0	0	0	0	0	1.0000	0
28. Psychologist	7231	0	0	0	0	0	1.0000	0
29. Psychology Assistant	7241	0	0	0	0	0	1.0000	0
30. Social Work/Counseling	7251	0	0	0	0	0	1.0000	0
31. Social Services/Pastoral Care	7261	0	2,240	2,240	0	2,240	1.0000	2,240
32. Habilitation Supervisor	7271	0	0	0	0	0	1.0000	0
33. Program Director	7281	0	0	0	0	0	1.0000	0
34. Qualified Mental Retardation Professional	7291	0	0	0	0	0	1.0000	0
<b>35. TOTAL Activities, Habilitation and Social Services (sum of lines 25 through 34)</b>		<b>22,569</b>	<b>2,240</b>	<b>24,809</b>	<b>0</b>	<b>24,809</b>		<b>24,809</b>
<b>MEDICAL MINOR EQUIPMENT</b>								
36. Medical Minor Equip. - Medicare Billable	7301		280	280	0	280	1.0000	280
37. Medical Minor Equip. - Medicare Non-Billable	7302		13	13	0	13	1.0000	13
<b>38. TOTAL Medical Minor Equipment (sum of lines 36 through 37)</b>		<b>0</b>	<b>293</b>	<b>293</b>	<b>0</b>	<b>293</b>		<b>293</b>

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
<b>UTILITY COSTS</b>								
39. Heat, Light, Power	7501		42,683	42,683	0	42,683	1.0000	42,683
40. Water and Sewage	7511	97	13,690	13,787	0	13,787	1.0000	13,787
41. Trash and Refuse Removal	7521		4,832	4,832	0	4,832	1.0000	4,832
42. Hazardous Medical Waste Collection	7531		1,298	1,298	0	1,298	1.0000	1,298
<b>43. TOTAL Utility Costs (sum of lines 39 through 42)</b>		97	62,503	62,600	0	62,600		62,600
<b>ADMINISTRATIVE AND GENERAL SERVICES</b>								
44. Administrator	7600	0	21,060	21,060	0	21,060	1.0000	21,060
45. Other Administrative Personnel	7605	21,495	0	21,495	0	21,495	1.0000	21,495
46. Consulting & Mgmt. Fees - Ancillary/Support	7610		0	0	0	0	1.0000	0
47. Office and Administrative Supplies	7615		3,476	3,476	0	3,476	1.0000	3,476
48. Communications	7620		4,632	4,632	0	4,632	1.0000	4,632
49. Security Services	7625	0	2,216	2,216	0	2,216	1.0000	2,216
50. Travel and Entertainment	7630		5,055	5,055	0	5,055	1.0000	5,055
51. Laundry/Housekeeping Supervisor	7635	23,871	0	23,871	0	23,871	1.0000	23,871
52. Housekeeping	7640	5,723	4,519	10,242	0	10,242	1.0000	10,242
53. Laundry and Linen	7645	14,434	8,373	22,807	0	22,807	1.0000	22,807
54. Legal Services	7650		52	52	0	52	1.0000	52
55. Accounting	7655	23,303	2,610	25,913	0	25,913	1.0000	25,913
56. Dues, Subscriptions and Licenses	7660		8,641	8,641	0	8,641	1.0000	8,641
57. Interest - Other	7665		313	313	-53	260	1.0000	260
58. Insurance	7670		36,627	36,627	0	36,627	1.0000	36,627
59. Data Services	7675	0	5,718	5,718	0	5,718	1.0000	5,718
60. Help Wanted/Informational Advertising	7680		7,248	7,248	0	7,248	1.0000	7,248
61. Amortization of Start-Up Costs	7685		0	0	0	0	1.0000	0
62. Amortization of Organizational Costs	7686		0	0	0	0	1.0000	0
63. Other Ancillary/Support - Specify below	7690	0	0	0	0	0	1.0000	0
64. Home Office Costs - Ancillary/Support **	7695	42,296	52,585	94,881	-4,852	90,029	1.0000	90,029
<b>65. TOTAL Administrative and General Services (sum of lines 44 thru 64)</b>		131,122	163,125	294,247	-4,905	289,342		289,342
<b>MAINTENANCE AND MINOR EQUIPMENT</b>								
66. Plant Operations/Maintenance Supervisor	7700	5,576	0	5,576	0	5,576	1.0000	5,576
67. Plant Operations and Maintenance	7710	13,145		13,145	0	13,145	1.0000	13,145
68. Repair and Maintenance	7720		15,859	15,859	0	15,859	1.0000	15,859
69. Minor Equipment	7730		2,055	2,055	0	2,055	1.0000	2,055
70. Leased Equipment	7740		0	0	0	0	1.0000	0
<b>71. TOTAL Maintenance and Minor Equipment (sum of lines 66 through 70)</b>		18,721	17,914	36,635	0	36,635		36,635

\*\* Home Office Costs are to be entered on line 64 only. They are not be distributed to any other line on this schedule \*\*

Line 63 Other Ancillary/Support

Account Title	Salary Column 1	Other Column 2
<b>Totals (must tie to line 63, Columns 1 and 2)</b>		

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/Contract Wages (2)	Total (Col 1 + Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc *** (6)	Allocated Adjust. Total (Col 5 x Col 6) (7)
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT</b>								
72. Payroll Taxes - Ancillary/Support	7800		7,845	7,845	0	7,845	1.0000	7,845
73. Workers' Compensation - Ancillary/Support	7810		3,101	3,101	0	3,101	1.0000	3,101
74. Employee Fringe Benefits - Ancillary/Support	7820		10,303	10,303	0	10,303	1.0000	10,303
75. EAP Administrator - Ancillary/Support	7830	0	0	0	0	0	1.0000	0
76. Self Funded Prog. Admin. - Ancillary/Support	7840	0	0	0	0	0	1.0000	0
77. Staff Development - Ancillary/Support	7850	0	234	234	0	234	1.0000	234
78. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 72 through 77)		0	21,483	21,483	0	21,483		21,483
79. TOTAL Reimbursable Ancillary/Support Cost (sum of lines 18, 24, 35, 38, 43, 65, 71, and 78)		236,707	323,259	559,966	-4,905	555,061		555,061
<b>NON-REIMBURSABLE EXPENSES</b>								
80. Physical Therapist	9600	0	33,747	33,747	0	33,747	1.0000	33,747
81. Physical Therapy Assistant	9610	0	0	0	0	0	1.0000	0
82. Occupational Therapist	9620	0	16,135	16,135	0	16,135	1.0000	16,135
83. Occupational Therapist Assistant	9630	0	0	0	0	0	1.0000	0
84. Speech Therapist	9640	0	680	680	0	680	1.0000	680
85. Audiologist	9650	0	0	0	0	0	1.0000	0
86. Payroll Taxes - Therapy	9660		0	0	0	0	1.0000	0
87. Workers' Compensation - Therapy	9670		0	0	0	0	1.0000	0
88. Employee Fringe Benefits - Therapy	9680		0	0	0	0	1.0000	0
89. EAP Administrator - Therapy	9690	0	0	0	0	0	1.0000	0
90. Self Funded Program Admin. - Therapy	9695	0	0	0	0	0	1.0000	0
91. Staff Development - Therapy	9700	0	0	0	0	0	1.0000	0
92. Legend Drugs	9705		10,997	10,997	0	10,997	1.0000	10,997
93. Radiology	9710		589	589	0	589	1.0000	589
94. Laboratory	9715		1,816	1,816	0	1,816	1.0000	1,816
95. Oxygen	9720		0	0	0	0	1.0000	0
96. Other Non-Reimbursable - Specify Below	9725	0	6,946	6,946	0	6,946	1.0000	6,946
97. Late Fees, Fines or Penalties	9730		0	0	0	0	1.0000	0
98. Federal Income Tax	9735		0	0	0	0	1.0000	0
99. State Income Tax	9740		0	0	0	0	1.0000	0
100. Local Income Tax	9745		0	0	0	0	1.0000	0
101. Insurance - Officers' Life	9750		0	0	0	0	1.0000	0
102. Promotional Advertising and Marketing	9755	0	5,198	5,198	0	5,198	1.0000	5,198
103. Contributions and Donations	9760		0	0	0	0	1.0000	0
104. Bad Debt	9765		0	0	0	0	1.0000	0
105. Parenteral Nutrition Therapy	9770		0	0	0	0	1.0000	0
106. Franchise Permit Fees	9776		68,438	68,438	0	68,438	1.0000	68,438
107. TOTAL Non-Reimbursable Expenses (sum of lines 80 through 106)		0	144,546	144,546	0	144,546		144,546
108. TOTAL Ancillary/Support Cost Reimbursable and Non-Reimbursable (sum of lines 79 and 107)		236,707	467,805	704,512	-4,905	699,607		699,607

Line 96 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
<b>Totals (must tie to line 96, Columns 1 and 2)</b>		

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

4.1

Schedule C-1

ADMINISTRATORS COMPENSATION

Provider Name <b>MORNING VIEW CARE CENTER OF MARION</b>	Medicaid Provider Number <b>0001910</b>	Reporting Period From: <b>01/01/2006</b> Through: <b>12/31/2006</b>
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SECTION A:

First Name of Administrator <b>DIXIE</b>	Last Name of Administrator <b>Waite</b>	Administrator License Number* <b>XXXXXXXXXXXX</b>	Social Security No. <b>XXX-XX-XXXX</b>
Relationship to Provider: Is the administrator an owner/relative? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
1. Base percentage allowance			100%
2. Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years)			10 Times 4 = 40%
3. Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate is not obtained)			0 Times 5 = 0%
3.1 Was baccalaureate degree obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
4. Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)			
a. Accounting		0	
b. Maintenance		0	
c. Housekeeping		0	
d. Other, specify		0	
d. Other, specify		0	
Total Duties		0	Times 4 = 0%
5. County Adjustment (see instructions)			0%
6. Ownership Points (see instructions)			0%
7. Subtotal of lines 1 through 6			140%
8. Allowance Percentage (enter line 7, not to exceed 150%)			140%

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Paid Weekly		Compensation		
Beginning Date (MMDDYY) (1)	Ending Date (MMDDYY) (2)	Hrs. ** (3)	% (4)	Account Number *** (5)	Column Number (6)	Amount (7)
01/01/2006	12/31/2006	16.00	40.00	7600	7	21.060
<b>TOTAL COMPENSATION</b>						<b>21,060</b>

\* ADMINISTRATORS OF HOSPITAL BASED NURSING FACILITIES REPORT SOCIAL SECURITY NUMBER.

\*\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN (7) IS ALLOCATED, HOURS PAID MUST BE ALLOCATED USING THE SAME RATIO.

\*\*\* THIS SCHEDULE MUST BE COMPLETED FOR ALL ADMINISTRATORS REGARDLESS OF WHETHER THE ADMINISTRATOR'S SALARY IS REPORTED IN ACCOUNT NUMBER 7600 OR ACCOUNT NUMBER 7695. (USE ONLY ACCOUNT NUMBER 7600 OR 7695, WHICHEVER IS APPROPRIATE.)

OWNERS'/RELATIVES' COMPENSATION  
OTHER THAN COMPENSATION FOR FACILITY ADMINISTRATOR DUTIES

Provider Name <b>MORNING VIEW CARE CENTER OF MARION</b>	Medicaid Provider Number <b>0001910</b>	Reporting Period From: <b>01/01/2006</b> Through: <b>12/31/2006</b>
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Instructions: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed.

Detail owners' and/or relatives' compensation included on JFS 02524N, Schedules B-2 and C net of applicable column 4 adjustments.

Individual's Name (1)	Social Security Number (2)	Position Number ** (3)	Relationship to Owner (4)	Years of Exper. (5)	Dates of Employment During this Reporting Period		Paid Weekly		Compensation		
					Beginning (6)	Ending (7)	Hrs. * (8)	% (9)	Account Number (10)	Col. No. (11)	Amount (12)
PEGGY DEARTH	XXX-XX-XXXX	BS02	WIFE	25	1/1/2006	12/31/2006	3.36	11.20	7605	7	6,720
GLEN DEARTH	XXX-XX-XXXX	CP02	OWNER	25	1/1/2006	12/31/2006	4.48	11.20	7605	7	11,648

\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 12 IS ALLOCATED, HOURS PAID MUST BE ALLOCATED THE SAME WAY.  
 \*\* SEE COST REPORT INSTRUCTIONS PAGES 23, 24 AND 25 FOR POSITION NUMBERS.

OWNERS'/RELATIVES' COMPENSATION

Provider Name <b>MORNING VIEW CARE CENTER OF MARION</b>	Medicaid Provider Number <b>0001910</b>	Reporting Period From: <b>01/01/2006</b> Through: <b>12/31/2006</b>
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Instructions: All items within this schedule must be completed. List all compensation received from other long-term care facilities in the Medicaid program (in Ohio or other states) by persons listed on Sch. C-2, page 1 of 2, and/or owning a 5% or more interest in this facility.

Individual's Name (1)	Social Security Number (2)	Facility Name (3)	No. of Beds (4)	Medicaid Provider No. (5)	Paid Weekly		Amount of Compensation (8)
					Hrs. (6) *	% (7)	
PEGGY DEARTH	XXX-XX-XXXX	MVCC - CENTERBURG	34	0398574	3.7	9.30	7,440
PEGGY DEARTH	XXX-XX-XXXX	MVCC - DANVILLE	42	4923202	3.3	8.33	6,660
GLEN DEARTH	XXX-XX-XXXX	MVCC - CENTERBURG	34	0398574	5.0	12.40	12,896
GLEN DEARTH	XXX-XX-XXXX	MVCC - DANVILLE	42	4923202	4.4	11.10	11,544
GLEN DEARTH	XXX-XX-XXXX	BENNINGTON GLEN	79	2161539	17.4	43.60	45,344
PEGGY DEARTH	XXX-XX-XXXX	BENNINGTON GLEN	79	2161539	13.1	32.70	26,160

\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN 8 IS ALLOCATED, HOURS PAID MUST BE ALLOCATED THE SAME WAY.

COST OF SERVICES FROM RELATED PARTIES

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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1. In the amount of costs to be reimbursed by the Ohio Medicaid Program, are any costs included which are a result of transactions with a related party? \*  
 Yes       No      If Yes, complete item 2

2. Does this cost report include payments to related parties in excess of the costs to the related party?  
 Yes       No      If Yes, complete the table below

Name of Owner (1)	Social Security No. (2)	Name of Related Party (3)	Federal ID. No. (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Party (9)

\* FOR FURTHER EXPLANATION SEE OHIO ADMINISTRATIVE CODE:  
 JFS 02524N (REV. 02/2006)



COST OF SERVICES FROM RELATED PARTIES

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?

Yes  No If yes, list names below:

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Job and Family Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, the Ohio Department of Commerce, or the Ohio Department of Industrial Commission within the previous twelve months?

Yes  No If yes, list names below:

Name	Social Security Number	Name	Social Security Number

8. List all contracts in effect during the cost report period for which the imputed value or cost of goods or service from any individual or organization is ten thousand dollars or more in a twelve month period.

Contractor Name	Contract Amount	Goods or Services Provided
In House Rehab Group	50,562	Therapy Services

## CAPITAL COST CENTER

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.

Facilities that did change operator on or after 7/01/93 use groups A and B.

**GROUP A ASSETS ACQUIRED**

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
1. Depreciation - Building	8010	8,620	0	8,620	1.0000	8,620
2. Amortization - Land Improvements	8020	2,920	640	3,560	1.0000	3,560
3. Amortization - Leasehold Improvements	8030	1,361	0	1,361	1.0000	1,361
4. Depreciation - Equipment	8040	3,570	0	3,570	1.0000	3,570
5. Depreciation - Transportation Equipment	8050	0	0	0	1.0000	0
6. Lease and Rent - Building	8060	0	0	0	1.0000	0
7. Lease and Rent - Equipment	8065	7,824	0	7,824	1.0000	7,824
8. Interest Exp. - Prop., Plant and Equip.	8070	19,458	0	19,458	1.0000	19,458
9. Amortization of Financing Costs	8080	4,979	0	4,979	1.0000	4,979
10. Nonextensive Renovations - Depreciation/Amortization and Interest	8085, 8086, 8087	980	0	980	1.0000	980
11. Home Office Costs - capital **	8090	14,287	-224	14,063	1.0000	14,063
<b>12. TOTAL Capital Costs Group A</b>		<b>63,999</b>	<b>416</b>	<b>64,415</b>		<b>64,415</b>

\*\* Home Office Costs are to be entered on line 11 only. They are not to be distributed to any other line in Group A.

**GROUP B ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR**

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.

Leased facilities that changed operator on or after 5/27/92 use this group to report expenses incurred through a change of operator on or after 5/27/92.

[Use column (4) to adjust reported costs to the allowable costs as defined in Ohio Administrative Code.]

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total (Col 3 + Col 4) (5)	Alloc. *** (6)	Allocated Adjusted Total (Col 5 * Col 6) (7)
13. Depreciation - Building	8110	0	0	0	1.0000	0
14. Depreciation - Equipment	8140	0	0	0	1.0000	0
15. Interest Exp. - Prop., Plant and Equip.	8170	0	0	0	1.0000	0
16. Amortization of Financing Costs	8180	0	0	0	1.0000	0
17. Lease Expense	8195	0	0	0	1.0000	0
<b>18. TOTAL Capital Costs Group B</b>		<b>0</b>	<b>0</b>	<b>0</b>		<b>0</b>

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

4.1

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Schedule D-1

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.  
Facilities that did change operator on or after 7/01/93 use groups A and B.

**GROUP A ASSETS ACQUIRED**

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
1. Land		9,000	0	9,000		9,000	
2. Buildings		139,061	2,155	141,216	82,189	59,027	8,620
3. Land Improvements	10/01/1994	62,159	-193	61,966	31,928	30,038	2,920
4. Leasehold Improvements	08/30/1981	26,406	0	26,406	23,972	2,434	1,361
5. Equipment	12/31/1980	68,129	3,127	71,256	58,573	12,683	3,570
6. Transportation		0	0	0	0	0	0
7. Financing Costs		0	0	0	0	0	4,979
8. <b>TOTAL</b>		304,755	5,089	309,844	196,662	113,182	21,450

**NONEXTENSIVE RENOVATIONS**

INSTRUCTIONS: Complete for nonextensive renovations in use during cost report period and completed prior to 7/1/05.

ACCOUNT	Cost at Beginning of Period (1)	Additions or Reductions (2)	Project Cost End of Period (Col 1 + Col 2) (3)	Accumulated Depreciation End of Period (4)	Net Book Value End of Period (Col 3 - Col 4) (5)	Depreciation/ Amortization this Period (6)	Interest this Period (7)	Total Columns 6 and 7 (8) **
9. Depreciation/Amortization and Interest	230,065	0	230,065	0	230,065	172	808	980
10. <b>TOTAL</b>	230,065	0	230,065	0	230,065	172	808	980

**GROUP B ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR**

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
11. Land		0				0	
12. Buildings		0			0	0	0
13. Equipment		0			0	0	0
14. Financing Costs		0			0	0	0
15. <b>TOTAL</b>		0			0	0	0

Has there been any change in the original historical cost of capital assets?

     YES   X   NO

If yes, submit complete detail.



## BALANCE SHEET

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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CURRENT ASSETS	Chart of Acct. No.	BALANCE PER BOOKS	
		Beginning of Period	End of Period
1. Petty Cash	1001	150	150
2. Cash In Banks - General Account	1010	5,905	-159
3. Accounts Receivable	1030	125,456	117,103
4. Allowance For Uncollectible Accounts	1040	0	0
5. Notes Receivable	1050	0	0
6. Allowance For Uncollectible Notes Receivable	1060	0	0
7. Other Receivables	1070	0	0
8. Cost Settlement	1080	0	0
9. Inventories	1090	4,070	2,846
10. Prepaid Expenses	1100	9,355	7,546
11. Short-Term Investments	1110	0	0
12. Special Expenses	1120	0	0
13. Total Current Assets (sum of lines 1 through 12)		144,936	127,486
<b>PROPERTY, PLANT AND EQUIPMENT</b>			
14. Property, Plant and Equipment	1200	304,755	309,845
15. Accumulated Depreciation and Amortization	1250	-180,857	-196,986
16. Nonextensive Renovations	1300	230,065	230,065
17. Accumulated Depreciation and Amortization - Nonextensive Renovations	1350	-230,065	-230,065
18. Total Property, Plant and Equipment (sum of lines 14 through 17)		123,898	112,859
<b>OTHER ASSETS</b>			
19. Non-Current Investments	1400	0	0
20. Deposits	1410	15,911	16,006
21. Due From Owners / Officers (to Sch. E-1, line 2)	1420	217,847	36,339
22. Deferred Charges and Other Assets	1430	36,824	149,497
23. Notes Receivable - Long-Term	1440	0	0
24. Total Other Assets (sum of lines 19 through 23)		270,582	201,842
25. Total Assets (sum of lines 13, 18 and 24)		539,416	442,187
<b>CURRENT LIABILITIES (Report credit balances as positive amounts)</b>			
26. Accounts Payable	2010	88,519	103,990
27. Cost Settlements	2020	0	0
28. Notes Payable	2030	0	0
29. Current Portion of Long-Term Debt	2040	0	0
30. Accrued Compensation	2050	32,854	38,346
31. Payroll Related Withholdings and Liabilities	2060	4	7,122
32. Taxes Payable	2080	5,739	5,844
33. Other Liabilities - Specify below	2090	112,469	93,846
34. Total Current Liabilities (sum of lines 26 through 33)		239,585	249,148
<b>LONG-TERM LIABILITIES (Report credit balances as positive amounts)</b>			
35. Long-Term Debt	2410	223,428	228,553
36. Related Party Loans - Interest Allowable	2420	0	0
37. Related Party Loans - Interest Non-Allowable(to Sch E-1, line 3)	2430	0	0
38. Non-Interest Bearing Loans From Owners(to Sch E-1, line 4)	2440	0	0
39. Deferred Liabilities	2450	0	0
40. Total Long-Term Liabilities (sum of lines 35 through 39)		223,428	228,553
41. Total Liabilities (sum of lines 34 and 40)		463,013	477,701
42. Capital (line 25 less line 41) (to Sch E-1, line 1)	3000	76,403	-35,514
43. Total Liabilities and Capital (must equal line 25)		539,416	442,187

## Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
Accrued interest	-920.00	0.00
Accrued Franchise Permit Fee	-111,549.00	-93,846.00
<b>TOTALS (must tie to line33)</b>	<b>-920.00</b>	<b>0.00</b>

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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**SECTION A: TOTAL EQUITY**

TOTAL EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch E, line 42)	76,403	(35,514)
2. Due From Owners/Officers (from Sch E, line 21)	(217,847)	(36,339)
3. Related Party Loans - Interest Non-Allowable (from Sch E, line 37)	0	0
4. Non-Interest Bearing Loans From Owners (from Sch E, line 38)	0	0
5. Equity in Assets Leased From Related Party (attach detail)		
6. Home Office Equity (attach detail)	(185,484)	(73,815)
7. Cash Surrender Value of Life Insurance Policy		
8. Other, Specify	327	323
9. Other, Specify		
10. Other, Specify		
11. Other, Specify		
12. Other, Specify		
13. Other, Specify		
14. Other, Specify		
15. Other, Specify		
16. Other, Specify		
17. Other, Specify		
18. Other, Specify		
19. Other, Specify		
20. Other, Specify		
21. Other, Specify		
22. Total Equity (column 1 to E-1, line 23, column 2) (column 2 to E-1, line 34, column 8)	(326,601)	(145,345)

## RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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## SECTION B: CHANGES TO EQUITY

Month (1)	Equity Beginning of Period (2)	Capital Investments During Period (3)	Gain (Loss) On Disposal of Assets (4)	Withdrawals, or Dividend Distribution (5)	Other Increase / (Decrease) (6)	Increases or (Decreases) Due to Operations (7)	Equity Capital End of Month (net total of columns 2-7) (8) *
23. January	-326,601	0	0	( 0 )	24,342	-9,237	0
24. February	-326,601	0	0	( 0 )	48,684	-18,474	0
25. March	-326,601	0	0	( 0 )	73,025	-27,711	0
26. April	-326,601	0	0	( 0 )	97,367	-36,948	0
27. May	-326,601	0	0	( 0 )	121,709	-46,185	0
28. June	-326,601	0	0	( 0 )	146,051	-55,423	0
29. July	-326,601	0	0	( 0 )	170,392	-64,660	0
30. August	-326,601	0	0	( 0 )	194,734	-73,897	0
31. September	-326,601	0	0	( 0 )	219,076	-83,134	0
32. October	-326,601	0	0	( 0 )	243,418	-92,371	0
33. November	-326,601	0	0	( 0 )	267,759	-101,608	0
34. December	-326,601	0	0	( 0 )	292,101	-110,845	0

\* If the result in Column 8, lines 23 - 34 is a negative figure, enter "0" on lines 23 - 34. Do not enter less than zero.

## REVENUE TRIAL BALANCE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>ROUTINE SERVICE - ROOM AND BOARD</b>				
1. Private	5010	79,714	0	79,714
2. Medicare	5011	53,025	0	53,025
3. Medicaid	5012	992,152	0	992,152
4. Veterans	5013	0	0	0
5. Other	5014	0	0	0
6. TOTAL Routine Service - Room and Board(lines 1 through 5)		1,124,891	0	1,124,891
<b>DEDUCTIONS FROM REVENUES</b>				
7. Contractual Allowance-Medicare	5710	-38,102	0	-38,102
8. Contractual Allowance-Medicaid	5720	-26,204	0	-26,204
9. Contractual Allowance-Other	5730	0	0	0
10. Charity Allowance	5740	0	0	0
11. TOTAL Deductions from Revenues(lines 7 through 10)		-64,306	0	-64,306
<b>THERAPY SERVICES</b>				
12. Physical Therapy	5020	95,895	0	95,895
13. Occupational Therapy	5030	45,000	0	45,000
14. Speech Therapy	5040	1,950	0	1,950
15. Audiology Therapy	5050	0	0	0
16. Respiratory Therapy	5060	0	0	0
17. TOTAL (lines 12 through 16)		142,845	0	142,845
<b>MEDICAL SUPPLIES</b>				
18. Medicare B - Medicaid(To Sch A-2, Line 1a, Col.2)	5070-1	0	0	0
19. Medicare B - Other (To Sch A-2, Line 1a, Col.3)	5070-2	1,729	0	1,729
20. Private (To Sch A-2, Line 1a, Col.4)	5070-3	0	0	0
21. Medicare A (To Sch A-2, Line 1a, Col.5)	5070-4	1,348	0	1,348
22. Veterans (To Sch A-2, Line 1a, Col.6)	5070-5	0	0	0
23. Other (To Sch A-2, Line 1a, Col.6)	5070-6	0	0	0
24. Medicaid (To Sch A-2, Line 1a, Col.7)	5070-7	17,762	0	17,762
25. Medical Supplies-Routine	5080	0	0	0
26. Habilitation Supplies	5085	0	0	0
27. TOTAL Medical Supplies(lines 18 through 26)		20,839	0	20,839
<b>MEDICAL MINOR EQUIPMENT</b>				
28. Medicare B - Medicaid (To Sch. A-2, Line 2a, Col. 2)	5090-1	0	0	0
29. Medicare B - Other(To Sch. A-2, Line 2a, Col. 3)	5090-2	0	0	0
30. Private (To Sch. A-2, Line 2a, Col. 4)	5090-3	0	0	0
31. Medicare A (To Sch. A-2, Line 2a, Col. 5)	5090-4	0	0	0
32. Veterans (To Sch. A-2, Line 2a, Col. 6)	5090-5	0	0	0
33. Other (To Sch. A-2, Line 2a, Col. 6)	5090-6	0	0	0
34. Medicaid (To Sch. A-2, Line 2a, Col. 7)	5090-7	0	0	0
35. Medical Minor Equipment-Routine	5100	0	0	0

REVENUE TRIAL BALANCE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
36. TOTAL Medical Minor Equipment(Lines 28 through 35)		0	0	0
<b>ENTERAL NUTRITION THERAPY</b>				
37. Medicare B - Medicaid (To Sch. A-2, Line 3a, Col. 2)	5110-1	1,564	0	1,564
38. Medicare B - Other(To Sch. A-2, Line 3a, Col. 3)	5110-2	0	0	0
39. Private (To Sch. A-2, Line 3a, Col. 4)	5110-3	0	0	0
40. Medicare A (To Sch. A-2, Line 3a, Col. 5)	5110-4	0	0	0
41. Veterans (To Sch. A-2, Line 3a, Col. 6)	5110-5	0	0	0
42. Other (To Sch. A-2, Line 3a, Col. 6)	5110-6	0	0	0
43. Medicaid (To Sch. A-2, Line 3a, Col. 7)	5110-7	0	0	0
44. Enteral Nutrition Therapy - Routine	5120	0	0	0
45. TOTAL Enteral Nutrition Therapy (lines 37 through 44)		1,564	0	1,564
<b>OTHER ANCILLARY SERVICE</b>				
46. Incontinence Supply	5140	0	0	0
47. Personal Care	5150	0	0	0
48. Laundry Service - Routine	5160	0	0	0
49. TOTAL Other Ancillary Service (lines 46 through 48)		0	0	0
<b>OTHER SERVICES</b>				
50. Dry Cleaning Service	5310	0	0	0
51. Communications	5320	0	0	0
52. Meals	5330	0	0	0
53. Barber and Beauty	5340	0	0	0
54. Personal Purchases - Residents	5350	0	0	0
55. Radiology	5360	907	0	907
56. Laboratory	5370	1,847	0	1,847
57. Oxygen	5380	0	0	0
58. Legend Drugs	5390	20,539	0	20,539
59. Other - Specify Below	5400	0	0	0
60. TOTAL Other Services (lines 50 through 59)		23,293	0	23,293

Line 59 Other

Account Title	Amount
Total (must tie to line 59, column 2)	

REVENUE TRIAL BALANCE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>NON-OPERATING</b>				
61. Management Services	5510	0	0	0
62. Cash Discounts	5520	0	0	0
63. Rebates and Refunds	5530	0	0	0
64. Gift Shop	5540	0	0	0
65. Vending Machine Revenues	5550	0	0	0
66. Vending Machine Commissions	5555	0	0	0
67. Rental - Space	5560	0	0	0
68. Rental - Equipment	5570	0	0	0
69. Rental - Other	5580	0	0	0
70. Interest Income - Working Capital	5590	53	-53	0
71. Interest Income - Restricted Funds	5600	0	0	0
72. Interest Income - Funded Depreciation	5610	0	0	0
73. Interest Income - Related Party Revenue	5620	0	0	0
74. Interest Income - Contributions	5625	0	0	0
75. Endowments	5630	0	0	0
76. Gain/Loss on Disposal of Assets	5640	-636	636	0
77. Gain/Loss on Sale of Investments	5650	0	0	0
78. Nurse Aide Training Program Revenue	5660	0	0	0
79. Contributions	5670	0	0	0
80. TOTAL Non-operating (lines 61 through 79)		-583	583	0
81. TOTAL (SUM OF LINES 6, 11, 17, 27, 36, 45, 49, 60 AND 80)		1,248,543	583	1,249,126

## ADJUSTMENT TO TRIAL BALANCE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2006 Through: 12/31/2006
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Description	Revenue Chart of Account #  (1)	Salary Increase (Decrease)  (2)	Other Increase (Decrease)  (3)	Total Increase (Decrease) (Col. 2 + Col. 3)  (4)	Expense Chart of Account #  (5)	Revenue Reference Attachment 1 Line (6)
1. Interest Income offset	5590	0	-53	-53	7665	
2. Adjust Gain/loss to CR depr sc	5640	0	-4	-4		
3. Loss on disposal of asset	5640	0	640	640	8020	
4. Adjust HO depreciation		0	-224	-224	8090	
5. Marketing Salary		-4,852	0	-4,852	7695	
6. A-2 Offset (Line 7, Col 2)		0	0	0	6301	
7. A-2 Offset (Line 7, Col 3)		0	0	0	7301	
8. A-2 Offset (Line 7, Col 4)		0	0	0	7055	
9. A-2 Offset (Line 12, Col 5)		0	0	0	7690	
10. TOTAL		-4,852	359	-4,493		

## MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Provider Name	Medicaid Provider Number	Reporting Period	
MORNING VIEW CARE CENTER OF MARION	0001910	From 1/1/2006	Through: 12/31/2006

As per the cost report instructions, any documentation (required by the Department, or needed to clarify individual line items or groupings) must be submitted as hard copy and labeled as an exhibit. To facilitate the reporting and review process of the submitted cost report (including exhibits) ODJFS requires that exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and shall be labeled accordingly. Exhibits 3 and 4, if needed, shall also be labeled accordingly. In certain situations, if exhibits 3 and 4 are not applicable, the corresponding exhibit number shall not be used. Any other additional exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

**Please attach one copy of the following:**

- Exhibit 1. Facility trial balance that details the general ledger account names as of December 31, 2006  
IF THE RECOMMENDED CHART OF ACCOUNTS PER OHIO ADMINISTRATIVE CODE IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT. (One copy with each cost report is required.)
- Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)
- Exhibit 3. Home office trial balances and the allocation work sheets that show how the home office trial balance is allocated to each individual facility's cost report. Include the account groupings for each home office account. The allocation procedures are pursuant to "CMS Publication 15-1," (REV. 11/05) (If applicable - One copy with each cost report is required.)
- Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported. (If applicable - One copy with each cost report is required)
- Exhibit 5. Any other documentation which is necessary to explain costs Identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8 col. 4.

Failure to cross-reference exhibits, to the applicable cost report schedule, line, and column qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to Ohio Administrative Code.

PAID NON-MEDICAID LEAVE DAYS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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INSTRUCTIONS:

Record monthly the Non-Medicaid leave days paid for by payers other than ODJFS. Paid Non-Medicaid leave days are hospital, therapeutic, or any other leave day paid for on behalf of a Non-Medicaid resident. Non-Medicaid leave days are counted as inpatient days proportionate to the Non-Medicaid per diem rate paid.

MONTH	TOTAL PAID NON-MEDICAID LEAVE DAYS
JANUARY	0
FEBRUARY	0
MARCH	0
APRIL	0
MAY	0
JUNE	0
JULY	0
AUGUST	0
SEPTEMBER	0
OCTOBER	0
NOVEMBER	0
DECEMBER	0
TOTAL	0

Percentage of per diem rate paid by Non-Medicaid residents for leave days

97.00

NURSE AIDE TRAINING STATISTICAL INFORMATION

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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SECTION A: NURSE AIDE CONTINUING EDUCATION

	JANUARY 1 through MARCH 31 (1)	APRIL 1 through JUNE 30 (2)	JULY 1 through SEPTEMBER 30 (3)	OCTOBER 1 through DECEMBER 31 (4)	TOTAL (col. 1 thru 4) (5)
1. Number of nurse aides completing continuing education.	0	3	2	1	6

SECTION B: NURSE AIDE TRAINING

	NUMBER OF NURSE AIDES				TOTAL (Sum of col. 1 - 4) (5)
	TRAINED IN THIS FACILITY		TRAINED IN OTHER LTCFs (3)	TRAINED FROM OTHER SOURCES (4)	
	Your Facility Nurse Aides (1)	Other Facilities Nurse Aides (2)			
2. Number of aides who completed training during cost report period.	7	0	0	3	10
3. Number of aides who dropped out of training during the cost report period.	0	0	0	0	0
4. Total aides (sum of lines 2 and 3)	7	0	0	3	10
5. Total number of state approved nurse aides on your payroll at the end of the cost report period.					13
6. Total number of state approved nurse aides, excluding line 5, at the end of the cost report period.					0

SECTION C: NURSE AIDE TRAINING AND/OR COMPETENCY EVALUATION PROGRAM PROHIBITIONS

7. In accordance with Section 1819(f)(2)(B)(iii)(l)(b) of the Social Security Act, was this facility subject to any Nurse Aide Training and/or Competency Evaluation Program prohibition from the Centers for Medicare and Medicaid Services of the Ohio Department of Health during the cost report period ?

No                       Yes                      If 'Yes', identify date spans of prohibition:

SANCTION PERIODS	START (1)	END(2)

## WAGE AND HOURS SURVEY

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2006 Through: 12/31/2006
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INSTRUCTIONS: REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED.

Column (C): Enter wages (net of adjustments) paid to facility personnel (This must agree with the sum of column 1 on schedules B-2, C and attachment 2, column2).

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with Schedule C-2).

Column (E): Column (C) minus Column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus Column (G).

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>DIRECT CARE NURSING AND HABILITATION/REHABILITATION</b>							
1. Medical Director	6100	0	0	0	0	0	0
2. Director of Nursing	6105	58,376	0	58,376	2,080	0	2,080
3. RN Charge Nurse	6110	0	0	0	0	0	0
4. LPN Charge Nurse	6115	0	0	0	0	0	0
5. Registered Nurse	6120	101,920	0	101,920	4,808	0	4,808
6. Licensed Practical Nurse	6125	117,596	0	117,596	6,343	0	6,343
7. Nurse Aides	6130	178,357	0	178,357	18,388	0	18,388
8. Habilitation Staff	6170	0	0	0	0	0	0
9. Respiratory Therapist	6185	0	0	0	0	0	0
10. Quality Assurance	6205	0	0	0	0	0	0
11. Consulting and Management Fees-Direct	6210	0	0	0	0	0	0
12. Other Direct Care - Specify below	6220	0	0	0	0	0	0
13. Home Office Costs/Direct Care (salary)	6230	0	0	0	0	0	0
<b>14. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 13)</b>		<b>456,249</b>	<b>0</b>	<b>456,249</b>	<b>31,619</b>	<b>0</b>	<b>31,619</b>
<b>NURSE AIDE TRAINING</b>							
15. In-House Trainer Wages	6500	2,241	0	2,241	119	0	119
16. Classroom Wages: Nurse Aides	6511	4,538	0	4,538	567	0	567
17. Clinical Wages: Nurse Aides	6521	581	0	581	73	0	73
<b>18. TOTAL Nurse Aide Training (sum of lines 15 through 17)</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - DIRECT CARE</b>							
19. EAP Administrator - Direct Care	6730	0	0	0	0	0	0
20. Self Funded Programs Administrator - Direct Care	6740	0	0	0	0	0	0
21. Staff Development - Direct Care	6750	353	0	353	17	0	17
<b>22. TOTAL Payroll Tax, Fringe Benefits, and Staff Development (sum of lines 19 through 21)</b>		<b>35,389</b>	<b>0</b>	<b>35,389</b>	<b>2,578</b>	<b>0</b>	<b>2,578</b>
<b>ANCILLARY/SUPPORT DIETARY COST</b>							
23. Dietitian	7000	12,680	0	12,680	384	0	384
24. Food Service Supervisor	7005	22,709	0	22,709	2,194	0	2,194
25. Dietary Personnel	7015	28,348	0	28,348	3,078	0	3,078
26. EAP Administrator - Dietary	7075	0	0	0	0	0	0
27. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	0
28. Staff Development - Dietary	7090	0	0	0	0	0	0
<b>29. TOTAL Dietary (sum of lines 23 through 28)</b>		<b>63,737</b>	<b>0</b>	<b>63,737</b>	<b>5,656</b>	<b>0</b>	<b>5,656</b>
<b>30. TOTAL Page 1 (sum of lines 14, 18, 22 and 29)</b>		<b>555,375</b>	<b>0</b>	<b>555,375</b>	<b>39,853</b>	<b>0</b>	<b>39,853</b>

## WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
MORNING VIEW CARE CENTER OF MARION		0001910		From: 1/1/2006		Through: 12/31/2006	
WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>HABILITATION AND PHARMACEUTICAL</b>							
31. Medical/Habilitation Records	7105	461	0	461	23	0	23
32. Pharmaceutical Consultant	7110	0	0	0	0	0	0
<b>33. TOTAL Habilitation and Pharmaceutical(sum of lines 31 &amp; 32)</b>		461	0	461	23	0	23
<b>ACTIVITIES, HABILITATION, AND SOCIAL SERVICES</b>							
34. Activity Director	7201	21,708	0	21,708	1,913	0	1,913
35. Activity Staff	7211	861	0	861	77	0	77
36. Recreational therapist	7221	0	0	0	0	0	0
37. Psychologist	7231	0	0	0	0	0	0
38. Psychology Assistant	7241	0	0	0	0	0	0
39. Social Work/Counseling	7251	0	0	0	0	0	0
40. Social Services/Pastoral Care	7261	0	0	0	0	0	0
41. Habilitation Supervisor	7271	0	0	0	0	0	0
42. Program Director	7281	0	0	0	0	0	0
43. Qualified Mental Retardation Professional	7291	0	0	0	0	0	0
<b>44. TOTAL Activities, Habilitation, and Social Services (sum of lines 34 through 43)</b>		22,569	0	22,569	1,990	0	1,990
<b>UTILITIES</b>							
45. Water and Sewage (salary only)	7511	97	0	97	7	0	7
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>							
46. Administrator	7600	0	0	0	0	0	0
47. Other Administrative Personnel	7605	21,495	18,368	3,127	510	408	102
48. Security Services (salary only)	7625	0	0	0	0	0	0
49. Laundry/Housekeeping Supervisor	7635	23,871	0	23,871	1,874	0	1,874
50. Housekeeping	7640	5,723	0	5,723	662	0	662
51. Laundry and Linen	7645	14,434	0	14,434	1,729	0	1,729
52. Accounting	7655	23,303	0	23,303	2,081	0	2,081
53. Data Services (salary only)	7675	0	0	0	0	0	0
54. Other Ancillary/Support (salary only)	7690	0	0	0	0	0	0
55. Home Office Ancillary/Support (salary only)	7695	37,444	0	37,444	1,148	0	1,148
<b>56. TOTAL Admin. &amp; General Services(sum of lines 46 thru 55)</b>		126,270	18,368	107,902	8,004	408	7,596
<b>MAINTENANCE PERSONNEL</b>							
57. Plant Operations Maintenance Supervisor	7700	5,576	0	5,576	266	0	266
58. Plant Operations and Maintenance	7710	13,145	0	13,145	960	0	960
<b>59. TOTAL Maintenance Personnel(sum of lines 57 and 58)</b>		18,721	0	18,721	1,226	0	1,226
<b>PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - ANCILLARY/SUPPORT</b>							
60. EAP Administrator - Ancillary/Support	7830	0	0	0	0	0	0
61. Self Funded Prog. Admin. - Ancillary/Support	7840	0	0	0	0	0	0
62. Staff Development - Ancillary/Support	7850	0	0	0	0	0	0
<b>63. TOTAL Payroll Taxes, Fringe Benefits, &amp; Staff Development - Ancillary/Support (sum of lines 60 thru 62)</b>		0	0	0	0	0	0
<b>64. TOTAL Page 2(sum of lines 33, 44, 45, 56, 59 and 63)</b>		168,118	18,368	149,750	11,250	408	10,842
<b>65. TOTAL Attachment 6 Pages 1 and 2 (sum of lines 30 &amp; 64)</b>		723,493	18,368	705,125	51,103	408	50,695

ADDENDUM FOR DISPUTED COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2006 Through: 12/31/2006
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INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code, that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From:" columns, the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To" columns, the schedule, line number, and reason you believe these costs should be reclassified.

Reclassification From:					Reclassification To:		
CURRENT COST CENTERS	Chart of Acct.	Salary Facility Employed (1)	Other/ Contract Wages (2)	Adjusted/ Allocated Total (3)	Schedule (4)	Line (5)	Reason (6)
<b>TAX COSTS</b>							
1.		0	0	0			
2.		0	0	0			
3.		0	0	0			
4.		0	0	0			
5. TOTAL Tax Costs (sum of lines 1 through 4)		0	0	0			
<b>DIRECT CARE COSTS</b>							
6.		0	0	0			
7.		0	0	0			
8.		0	0	0			
9.		0	0	0			
10. TOTAL Direct Care Costs (sum of lines 6 through 9)		0	0	0			
<b>ANICLLARY/SUPPORT COSTS</b>							
11.		0	0	0			
12.		0	0	0			
13.		0	0	0			
14.		0	0	0			
15. TOTAL Ancillary/Support Costs (sum of lines 11 through 14)		0	0	0			
<b>NON-REIMBURSABLE EXPENSES</b>							
16.		0	0	0			
17.		0	0	0			
18.		0	0	0			
19.		0	0	0			
20. TOTAL Non-Reimbursable Expenses (sum of lines 16 through 19)		0	0	0			
<b>CAPITAL COSTS</b>							
21.		0	0	0			
22.		0	0	0			
23.		0	0	0			
24.		0	0	0			
25. TOTAL Capital Cost (sum of lines 21 through 24)		0	0	0			
26. TOTAL COST CENTERS (sum of lines 5, 10, 15, 20, and 25)		0	0	0			

4.1

EMPLOYMENT RETENTION RATE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2006 Through: 12/31/2006
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- 1. Number of FTEs on first full payroll ending date of the cost reporting period 19.70
- 2. Number of FTEs on last payroll ending date of the cost reporting period remaining from line 1 12.10
- 3. Employee Retention Rate ((Line 2 divided by line 1)\*100%) 61.4213 %