

CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
--	--	--

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 **1/1/2005** and ending **12/31/2005** 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) SHEPHERD (First) TAMARA (M.I.) K		
Title VP FINANCE	Telephone Number Area Code (614) 847-1070	Fax Number Area Code (614) 847-1393

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

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

SUMMARY OF INPATIENT DAYS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
---	-------------------------------------	--

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.

	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	604	1.0	0.0	605.0	74	75	0	754.0
2. February	30	570	7.0	0.0	577.0	43	3	0	623.0
3. March	30	649	1.0	0.0	650.0	0	0	0	650.0
4. April	30	633	3.0	0.0	636.0	0	3	0	639.0
5. May	30	597	4.0	0.0	601.0	0	48	0	649.0
6. June	30	562	6.5	0.0	568.5	15	17	0	600.5
7. July	30	577	0.0	0.0	577.0	31	50	0	658.0
8. August	30	561	1.0	0.0	562.0	31	30	0	623.0
9. September	30	533	5.0	0.0	538.0	30	18	0	586.0
10. October	30	555	0.0	0.0	555.0	31	31	0	617.0
11. November	30	560	1.5	0.5	562.0	30	53	0	645.0
12. December	30	559	4.0	0.0	563.0	31	59	0	653.0
13. TOTAL (sum of lines 1 through 12)		6,960	34.0	0.5	6,994.5	316	387	0	7,697.5
						Schedule A, page 1, line 7, column 2		Schedule A, page 1, line 4, column 1	

4.1

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
--	--	--

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 SECTION A: REVENUES (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)					
1a. Medical Supplies Revenue	0	0	0	6,269	0	0	6,269
1b. Percent of Medical Supplies Revenue by Payer Source	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	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	126	293	0	0	0	0	419
3b. Percent of Enteral Feeding Revenue by Payer Source	30.07%	69.93%	0.00%	0.00%	0.00%	0.00%	100%
4. Total Revenue by Payer Source	126	293	0	6,269	0	0	6,688

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%	30.07%	
6. Costs (from Schedule B-2, column 3, lines 18 and Schedule C, lines 33 and 10)	8,257	119	419	
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	126	126

SECTION C: ANCILLARY/SUPPORT COSTS - OFFSET	
8. Ancillary/Support costs (Schedule C, Line 76, column 3 less Schedule C, lines 18, 24, 48, 49, 50 and 68, column 3)	342,493
9. Total costs (total of Schedule B-1 line 5, Schedule B-2, line 46, Schedule C, line 76, Schedule D, lines 12 and 18, column 3)	1,155,250
10. Ancillary/Support costs as a percent of total costs (line 8 divided by line 9)	0.2965
11. Costs offset (from line 7 column 5 above)	126
12. Ancillary/Support costs to be offset (line 10 times line 11) offset costs on Schedule C line 60 column 4	37

SUMMARY OF COSTS

Provider Name	Medicaid Provider Number	Reporting Period	
MORNING VIEW CARE CENTER OF MARION	0001910	From: 01/01/2005	Through: 12/31/2005

REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)
TAX COST CENTER			
1. Tax Cost	B1 line 5 Col 7		6,998
DIRECT CARE COST CENTER			
2. Direct Care Cost	B2 line 46 Col 7		542,571
ANCILLARY/SUPPORT COST CENTER			
3. Ancillary/Support Cost	C line 76 Col 7		542,085
CAPITAL COST CENTER			
4. Assets Acquired Group A	D line 12 Col 7	55,116	
5. Assets thru Change of Operator Group B	D line 18 Col 7	0	
6. TOTAL Capital Cost (sum of lines 4 and 5) col 2			55,116
7. TOTAL REIMBURSABLE COSTS (sum of lines 1, 2, 3 and 6) Col 3			1,146,770

RECONCILIATION OF COSTS

Schedule/ Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt) Allocated Adjusted Total (4)
8. B1/5	col 3 6,998	col 4 0	col 5 6,998	col 7 6,998
9. B2/46	col 3 542,571	col 4 0	col 5 542,571	col 7 542,571
10. C/105	col 3 754,481	col 4 -5,869	col 5 748,612	col 7 748,612
11. D/12	col 3 57,727	col 4 -2,611	col 5 55,116	col 7 55,116
12. D/18	col 3 0	col 4 0	col 5 0	col 7 0
13. Totals	\$ 1,361,777 ^(A)	\$ -8,480 ^(B)	\$ 1,353,297	\$ 1,353,297
14. Less Non-Reimbursable from Schedule C, page 3, line 104			col 5 (206,527)	col 7 (206,527)
15. Total Reimbursable			\$ 1,146,770 ^(C)	\$ 1,146,770 ^(C)

(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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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		5,739	5,739	0	5,739	1.0000	5,739
2. Personal Property Taxes	6070		1,259	1,259	0	1,259	1.0000	1,259
3. Franchise Tax (Attach FT 1120)	6080		0	0	0	0	1.0000	0
4. Commercial Activity Tax (CAT)	6085		0	0	0	0	1.0000	0
5. TOTAL Tax Costs (sum of lines 1 through 4)			6,998	6,998	0	6,998		6,998

*** 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

DIRECT CARE 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)
NURSING AND HABILITATION/REHABILITATION								
1. Medical Director	6100	0	3,600	3,600	0	3,600	1.0000	3,600
2. Director of Nursing	6105	55,265	0	55,265	0	55,265	1.0000	55,265
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	109,005	0	109,005	0	109,005	1.0000	109,005
6. Licensed Practical Nurse	6125	110,597	0	110,597	0	110,597	1.0000	110,597
7. Nurse Aides	6130	159,267		159,267	0	159,267	1.0000	159,267
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	2,700	2,700	0	2,700	1.0000	2,700
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	51	51	0	51	1.0000	51
14. Qualified Mental Retardation Professional	6240	0	0	0	0	0	1.0000	0
15. Program Director	6250	0	0	0	0	0	1.0000	0
16. Habilitation Supervisor	6260	0	0	0	0	0	1.0000	0
17. TOTAL Nursing and Habilitation/ Rehabilitation (sum of lines 1 through 16)		434,134	6,351	440,485	0	440,485		440,485
MEDICAL, HABILITATION, AND UNIVERSAL PRECAUTION SUPPLIES								
18. Medical Supplies - Medicare Billable	6301		8,257	8,257	0	8,257	1.0000	8,257
19. Medical Supplies - Medicare Non-Billable	6311		2,370	2,370	0	2,370	1.0000	2,370
20. Oxygen - Emergency stand-by	6321		24	24	0	24	1.0000	24
21. Habilitation Supplies	6330		387	387	0	387	1.0000	387
22. Universal Precaution Supplies	6340		2,816	2,816	0	2,816	1.0000	2,816
23. TOTAL Medical, Habilitation, and Universal Precaution Supplies (sum of lines 18 through 22)			13,854	13,854	0	13,854		13,854
PURCHASED NURSING SERVICES								
24. Registered Nurse - Purchased Nursing	6401		0	0	0	0	1.0000	0
25. Licensed Practical Nurse Purchased Nursing	6411		5,883	5,883	0	5,883	1.0000	5,883
26. Nurse Aides - Purchased Nursing	6421		2,192	2,192	0	2,192	1.0000	2,192
27. TOTAL Purchased Nursing (sum of lines 24 through 26)			8,075	8,075	0	8,075		8,075

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: 1/1/2005 Through: 12/31/2005				
DIRECT CARE 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)
NURSE AIDE TRAINING								
28. In-House Trainer Wages	6500	1,793	0	1,793	0	1,793	1.0000	1,793
29. Classroom Wages - Nurse Aides	6511	4,267		4,267	0	4,267	1.0000	4,267
30. Clinical Wages - Nurse Aides	6521	420		420	0	420	1.0000	420
31. Books and Supplies	6531		81	81	0	81	1.0000	81
32. Transportation	6541		0	0	0	0	1.0000	0
33. Tuition Payments	6551		0	0	0	0	1.0000	0
34. Tuition Reimbursement	6560		0	0	0	0	1.0000	0
35. Contractual Payments to Other NFs	6570		0	0	0	0	1.0000	0
36. Registration Fees/Application Fees	6580		502	502	0	502	1.0000	502
37. Employee Fringe Benefits	6590		0	0	0	0	1.0000	0
38. TOTAL Nurse Aide Training (sum of lines 28 through 37)		6,480	583	7,063	0	7,063		7,063
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOP. (No Purchased Nursing)								
39. Payroll Taxes - Direct Care	6700		31,688	31,688	0	31,688	1.0000	31,688
40. Workers' Compensation - Direct Care	6710		19,488	19,488	0	19,488	1.0000	19,488
41. Employee Fringe Benefits - Direct Care	6720		21,278	21,278	0	21,278	1.0000	21,278
42. EAP Administrator - Direct Care	6730	0	0	0	0	0	1.0000	0
43. Self Funded Programs Admin. - Direct Care	6740	0	0	0	0	0	1.0000	0
44. Staff Development - Direct Care	6750	0	640	640	0	640	1.0000	640
45. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 39 thru 44)		0	73,094	73,094	0	73,094		73,094
46. TOTAL REIMBURSABLE DIRECT CARE COST (sum of lines 17, 23, 27, 38, and 45)		440,614	101,957	542,571	0	542,571		542,571

*** 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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)
DIETARY COST								
1. Dietitian	7000	12,923	0	12,923	0	12,923	1.0000	12,923
2. Food Service Supervisor	7005	21,079	0	21,079	0	21,079	1.0000	21,079
3. Dietary Personnel	7015	27,482	0	27,482	0	27,482	1.0000	27,482
4. Dietary Supplies and Expenses	7025		3,164	3,164	0	3,164	1.0000	3,164
5. Dietary Minor Equipment	7030		0	0	0	0	1.0000	0
6. Dietary Maintenance and Repair	7035		695	695	0	695	1.0000	695
7. Food In-Facility	7040		44,350	44,350	0	44,350	1.0000	44,350
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		419	419	-126	293	1.0000	293
11. Enterals: Medicare Non-Billable	7056		119	119	0	119	1.0000	119
12. Payroll Taxes - Dietary	7060		3,856	3,856	0	3,856	1.0000	3,856
13. Workers' Compensation - Dietary	7065		1,538	1,538	0	1,538	1.0000	1,538
14. Employee Fringe Benefits - Dietary	7070		678	678	0	678	1.0000	678
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	530	530	0	530	1.0000	530
18. TOTAL Dietary (sum of lines 1 through 17)		61,484	55,349	116,833	-126	116,707		116,707
MEDICAL RECORDS, PHARMACY & SUPPLIES								
19. Medical/Habilitation Records	7105	0	0	0	0	0	1.0000	0
20. Pharmaceutical Consultant	7110	0	0	0	0	0	1.0000	0
21. Incontinence Supplies	7115		1,644	1,644	0	1,644	1.0000	1,644
22. Personal Care - Supplies	7120		2,961	2,961	0	2,961	1.0000	2,961
23. Program Supplies	7125		821	821	0	821	1.0000	821
24. TOTAL Medical records, Pharmacy, and Supplies (sum of lines 19 through 23)		0	5,426	5,426	0	5,426		5,426
ACTIVITIES, HABILITATION & SOCIAL SERVICES								
25. Activity Director	7201	23,937	0	23,937	0	23,937	1.0000	23,937
26. Activity Staff	7211	2,529	0	2,529	0	2,529	1.0000	2,529
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	0	0	0	0	1.0000	0
32. TOTAL Activities, Habilitation and Social Services (sum of lines 25 through 31)		26,466	0	26,466	0	26,466		26,466
MEDICAL MINOR EQUIPMENT								
33. Medical Minor Equip. - Medicare Billable	7301		119	119	0	119	1.0000	119
34. Medical Minor Equip. - Medicare Non-Billable	7302		405	405	0	405	1.0000	405
35. TOTAL Medical Minor Equipment (sum of lines 33 through 34)			524	524	0.00	524		524
UTILITY COSTS								
36. Heat, Light, Power	7501		39,992	39,992	0	39,992	1.0000	39,992
37. Water and Sewage	7511	326	11,753	12,079	0	12,079	1.0000	12,079
38. Trash and Refuse Removal	7521		4,440	4,440	0	4,440	1.0000	4,440
39. Hazardous Medical Waste Collection	7531		449	449	0	449	1.0000	449
40. TOTAL Utility Costs(sum of lines 36 thru 39)		326	56,634	56,960	0	56,960		56,960

*** 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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)
ADMINISTRATIVE AND GENERAL SERVICES								
41. Administrator	7600	0	20,152	20,152	0	20,152	1.0000	20,152
42. Other Administrative Personnel	7605	20,949	0	20,949	0	20,949	1.0000	20,949
43. Consulting & Mgmt. Fees - Ancillary/Support	7610		0	0	0	0	1.0000	0
44. Office and Administrative Supplies	7615		4,032	4,032	0	4,032	1.0000	4,032
45. Communications	7620		4,838	4,838	0	4,838	1.0000	4,838
46. Security Services	7625	0	3,092	3,092	0	3,092	1.0000	3,092
47. Travel and Entertainment	7630		6,073	6,073	0	6,073	1.0000	6,073
48. Laundry/Housekeeping Supervisor	7635	25,081	0	25,081	0	25,081	1.0000	25,081
49. Housekeeping	7640	3,320	5,018	8,338	0	8,338	1.0000	8,338
50. Laundry and Linen	7645	13,379	3,379	16,758	0	16,758	1.0000	16,758
51. Legal Services	7650		0	0	0	0	1.0000	0
52. Accounting	7655	22,617	12,000	34,617	0	34,617	1.0000	34,617
53. Dues, Subscriptions and Licenses	7660		8,983	8,983	0	8,983	1.0000	8,983
54. Interest - Other	7665		59	59	-35	24	1.0000	24
55. Insurance	7670		39,450	39,450	0	39,450	1.0000	39,450
56. Data Services	7675	0	5,644	5,644	0	5,644	1.0000	5,644
57. Help Wanted/Informational Advertising	7680		5,644	5,644	0	5,644	1.0000	5,644
58. Amortization of Start-Up Costs	7685		0	0	0	0	1.0000	0
59. Amortization of Organizational Costs	7686		0	0	0	0	1.0000	0
60. Other Ancillary/Support - Specify below	7690	0	2,160	2,160	-37	2,123	1.0000	2,123
61. Home Office Costs - Ancillary/Support **	7695	41,637	40,897	82,534	-5,671	76,863	1.0000	76,863
62. TOTAL Administrative and General Services (sum of lines 41 thru 61)		126,983	161,421	288,404	-5,743	282,661		282,661
MAINTENANCE AND MINOR EQUIPMENT								
63. Plant Operations/Maintenance Supervisor	7700	4,060	0	4,060	0	4,060	1.0000	4,060
64. Plant Operations and Maintenance	7710	10,772		10,772	0	10,772	1.0000	10,772
65. Repair and Maintenance	7720		15,829	15,829	0	15,829	1.0000	15,829
66. Minor Equipment	7730		2,364	2,364	0	2,364	1.0000	2,364
67. Leased Equipment	7740		0	0	0	0	1.0000	0
68. TOTAL Maintenance and Minor Equipment (sum of lines 63 through 67)		14,832	18,193	33,025	0	33,025		33,025
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT								
69. Payroll Taxes - Ancillary/Support	7800		8,364	8,364	0	8,364	1.0000	8,364
70. Workers' Compensation - Ancillary/Support	7810		3,412	3,412	0	3,412	1.0000	3,412
71. Employee Fringe Benefits - Ancillary/Support	7820		8,128	8,128	0	8,128	1.0000	8,128
72. EAP Administrator - Ancillary/Support	7830	0	0	0	0	0	1.0000	0
73. Self Funded Prog. Admin. - Ancillary/Support	7840	0	0	0	0	0	1.0000	0
74. Staff Development - Ancillary/Support	7850	0	412	412	0	412	1.0000	412
75. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 69 through 74)		0	20,316	20,316	0	20,316		20,316
76. TOTAL Reimbursable Ancillary/Support Cost (sum of lines 18, 24, 32, 35, 40, 62, 68, and 75)		230,091	317,863	547,954	-5,869	542,085		542,085

** Home Office Costs are to be entered on line 62 only. They are not be distributed to any other line on this schedule **

Line 60 Other Ancillary/Support

Account Title	Salary Column 1	Other Column 2
Totals (must tie to line 60, Columns 1 and 2)		

*** 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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)
NON-REIMBURSABLE EXPENSES								
77. Physical Therapist	9600	0	78,726	78,726	0	78,726	1.0000	78,726
78. Physical Therapy Assistant	9610	0	0	0	0	0	1.0000	0
79. Occupational Therapist	9620	0	31,271	31,271	0	31,271	1.0000	31,271
80. Occupational Therapist Assistant	9630	0	0	0	0	0	1.0000	0
81. Speech Therapist	9640	0	6,093	6,093	0	6,093	1.0000	6,093
82. Audiologist	9650	0	0	0	0	0	1.0000	0
83. Payroll Taxes - Therapy	9660		0	0	0	0	1.0000	0
84. Workers' Compensation - Therapy	9670		0	0	0	0	1.0000	0
85. Employee Fringe Benefits - Therapy	9680		0	0	0	0	1.0000	0
86. EAP Administrator - Therapy	9690	0	0	0	0	0	1.0000	0
87. Self Funded Program Admin. - Therapy	9695	0	0	0	0	0	1.0000	0
88. Staff Development - Therapy	9700	0	0	0	0	0	1.0000	0
89. Legend Drugs	9705		15,698	15,698	0	15,698	1.0000	15,698
90. Radiology	9710		0	0	0	0	1.0000	0
91. Laboratory	9715		782	782	0	782	1.0000	782
92. Oxygen	9720		0	0	0	0	1.0000	0
93. Other Non-Reimbursable - Specify Below	9725	0	3,890	3,890	0	3,890	1.0000	3,890
94. Late Fees, Fines or Penalties	9730		0	0	0	0	1.0000	0
95. Federal Income Tax	9735		0	0	0	0	1.0000	0
96. State Income Tax	9740		0	0	0	0	1.0000	0
97. Local Income Tax	9745		0	0	0	0	1.0000	0
98. Insurance - Officers' Life	9750		0	0	0	0	1.0000	0
99. Promotional Advertising and Marketing	9755	0	12,218	12,218	0	12,218	1.0000	12,218
100. Contributions and Donations	9760		0	0	0	0	1.0000	0
101. Bad Debt	9765		0	0	0	0	1.0000	0
102. Parenteral Nutrition Therapy	9770		0	0	0	0	1.0000	0
103. Franchise Permit Fees	9776		57,849	57,849	0	57,849	1.0000	57,849
104. TOTAL Non-Reimbursable Expenses (sum of lines 77 through 103)		0	206,527	206,527	0	206,527		206,527
105. TOTAL Ancillary/Support Cost Reimbursable and Non-Reimbursable (sum of lines 76 and 104)		230,091	524,390	754,481	-5,869	748,612		748,612

Line 93 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
Totals (must tie to line 93, Columns 1 and 2)		

*** 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 MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
--	--	--

SECTION A:

First Name of Administrator DIXIE	Last Name of Administrator Waite	Administrator License Number* XXXXXXXXXXXX	Social Security Number XXX-XX-XXXX
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 =
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 =
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 =
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)
01/01/2005	12/31/2005	16.33	40.83	7600	7	20.152
TOTAL COMPENSATION						20,152

* 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 MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
--	--	--

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)	Hours * (8)	% (9)	Account Number (10)	Col. No. (11)	Amount (12)
PEGGY DEARTH	XXX-XX-XXXX	BS02	WIFE	25	1/1/2005	12/31/2005	5.24	14.60	7605	7	7,318
GLEN DEARTH	XXX-XX-XXXX	CP02	OWNER	25	1/1/2005	12/31/2005	5.24	14.60	7605	7	13,631

* 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 MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
---	-------------------------------------	--

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	5.9	14.85	8,294
PEGGY DEARTH	XXX-XX-XXXX	MVCC - DANVILLE	42	4923202	7.3	18.35	10,245
GLEN DEARTH	XXX-XX-XXXX	MVCC - CENTERBURG	34	0398574	5.9	14.85	15,449
GLEN DEARTH	XXX-XX-XXXX	MVCC - DANVILLE	42	4923202	7.3	18.35	19,083
GLEN DEARTH	XXX-XX-XXXX	BENNINGTON GLEN	79	2161539	13.8	34.53	35,895
PEGGY DEARTH	XXX-XX-XXXX	BENNINGTON GLEN	79	2161539	13.8	34.53	19,271

* 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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
 IFS 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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

3. List each individual, partner, related corporation, or related LLC which owns, in whole or in part, any mortgage or deed of trust, of the facility or of any property or asset of the provider.
(All individuals owning greater than 10% of the land or building, and/or greater than 5% of non real estate business, etc., must be identified by name and Social Security number.) *

Name	Title/Position (if applicable)	% Ownership	SSN or Fed ID #	Address	State	Zip Code
GLEN DEARTH		100.00	XXX-XX-XXXX	6195 STATE ROUTE #3	OH	43074

4. List all persons performing the duties of officer, director or equivalence (President, VP, Secretary, or other related positions).

Name	Social Security Number	Job Title(if applicable)
PEGGY DEARTH	XXX-XX-XXXX	CORPORATE SECRETARY
GLEN DEARTH	XXX-XX-XXXX	PRESIDENT
TAMARA SHEPHERD	XXX-XX-XXXX	VP FINANCE

5. List all other facilities that have related ownership as set forth in Section 5111.20 of the ORC.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds
MVCC - DANVILLE	4923202	42	BENNINGTON GLEN	2161539	79
MVCC - CENTERBURG	0398574	34			

* FOR FURTHER EXPLANATION SEE OHIO ADMINISTRATIVE CODE:

COST OF SERVICES FROM RELATED PARTIES

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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
Nursing Home Rehab Group	116,090	Therapy Services

CAPITAL COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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	8,133	0	8,133	1.0000	8,133
2. Amortization - Land Improvements	8020	2,894	0	2,894	1.0000	2,894
3. Amortization - Leasehold Improvements	8030	1,361	0	1,361	1.0000	1,361
4. Depreciation - Equipment	8040	3,812	-18	3,794	1.0000	3,794
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	7,580	0	7,580	1.0000	7,580
8. Interest Exp. - Prop., Plant and Equip.	8070	17,355	0	17,355	1.0000	17,355
9. Amortization of Financing Costs	8080	719	0	719	1.0000	719
10. Nonextensive Renovations - Depreciation/Amortization and Interest	8085, 8086, 8087	1,679	0	1,679	1.0000	1,679
11. Home Office Costs - capital **	8090	14,194	-2,593	11,601	1.0000	11,601
12. TOTAL Capital Costs Group A		57,727	-2,611	55,116		55,116

** 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
18. TOTAL Capital Costs Group B		0	0	0		0

*** 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: 1/1/2005 Through: 12/31/2005
--	--	--

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		135,495	3,567	139,062	73,741	65,321	8,133
3. Land Improvements	10/01/1994	61,150	1,009	62,159	29,351	32,808	2,894
4. Leasehold Improvements	08/30/1981	26,406	0	26,406	22,620	3,786	1,361
5. Equipment	12/31/1980	63,382	4,747	68,129	55,145	12,984	3,812
6. Transportation		0	0	0	0	0	0
7. Financing Costs		0	0	0	0	0	719
8. TOTAL		295,433	9,323	304,756	180,857	123,899	16,919

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	230,065	0	0	1,679	1,679
10. TOTAL	230,065	0	230,065	230,065	0	0	1,679	1,679

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. TOTAL		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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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	37,543	5,905
3. Accounts Receivable	1030	108,711	125,456
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	3,769	4,070
10. Prepaid Expenses	1100	9,222	9,355
11. Short-Term Investments	1110	0	0
12. Special Expenses	1120	0	0
13. Total Current Assets (sum of lines 1 through 12)		159,395	144,936
PROPERTY, PLANT AND EQUIPMENT			
14. Property, Plant and Equipment	1200	295,434	304,755
15. Accumulated Depreciation and Amortization	1250	-164,659	-180,857
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)		130,775	123,898
OTHER ASSETS			
19. Non-Current Investments	1400	0	0
20. Deposits	1410	15,911	15,911
21. Due From Owners / Officers (to Sch. E-1, line 2)	1420	242,366	217,847
22. Deferred Charges and Other Assets	1430	2,722	36,824
23. Notes Receivable - Long-Term	1440	0	0
24. Total Other Assets (sum of lines 19 through 23)		260,999	270,582
25. Total Assets (sum of lines 13, 18 and 24)		551,169	539,416
CURRENT LIABILITIES (Report credit balances as positive amounts)			
26. Accounts Payable	2010	73,072	88,519
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	34,359	32,854
31. Payroll Related Withholdings and Liabilities	2060	1,406	4
32. Taxes Payable	2080	5,098	5,739
33. Other Liabilities - Specify below	2090	95,053	112,469
34. Total Current Liabilities (sum of lines 26 through 33)		208,988	239,585
LONG-TERM LIABILITIES (Report credit balances as positive amounts)			
35. Long-Term Debt	2410	233,618	223,428
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)		233,618	223,428
41. Total Liabilities (sum of lines 34 and 40)		442,606	463,013
42. Capital (line 25 less line 41) (to Sch E-1, line 1)	3000	108,563	76,403
43. Total Liabilities and Capital (must equal line 25)		551,169	539,416

Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
Accrued interest	-754.00	-920.00
Accrued Franchise Permit Fee	-94,299.00	-111,549.00
TOTALS (must tie to line 33)	-754.00	-920.00

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

SECTION A: TOTAL EQUITY

TOTAL EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch E, line 42)	108,563	76,403
2. Due From Owners/Officers (from Sch E, line 21)	(242,366)	(217,847)
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)	(214,174)	(185,484)
7. Cash Surrender Value of Life Insurance Policy		
8. Other, Specify	310	327
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)	(347,667)	(326,601)

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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	-347,667	0	0	(0)	4,436	-2,680	0
24. February	-347,667	0	0	(0)	8,871	-5,360	0
25. March	-347,667	0	0	(0)	13,307	-8,040	0
26. April	-347,667	0	0	(0)	17,742	-10,720	0
27. May	-347,667	0	0	(0)	22,178	-13,400	0
28. June	-347,667	0	0	(0)	26,613	-16,080	0
29. July	-347,667	0	0	(0)	31,049	-18,760	0
30. August	-347,667	0	0	(0)	35,484	-21,440	0
31. September	-347,667	0	0	(0)	39,920	-24,120	0
32. October	-347,667	0	0	(0)	44,355	-26,800	0
33. November	-347,667	0	0	(0)	48,791	-29,480	0
34. December	-347,667	0	0	(0)	53,226	-32,160	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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
ROUTINE SERVICE - ROOM AND BOARD				
1. Private	5010	45,833	0	45,833
2. Medicare	5011	54,180	0	54,180
3. Medicaid	5012	1,029,018	0	1,029,018
4. Veterans	5013	0	0	0
5. Other	5014	0	0	0
6. TOTAL Routine Service - Room and Board(lines 1 through 5)		1,129,031	0	1,129,031
DEDUCTIONS FROM REVENUES				
7. Contractual Allowance-Medicare	5710	-92,871	0	-92,871
8. Contractual Allowance-Medicaid	5720	-43,709	0	-43,709
9. Contractual Allowance-Other	5730	0	0	0
10. Charity Allowance	5740	0	0	0
11. TOTAL Deductions from Revenues(lines 7 through 10)		-136,580	0	-136,580
THERAPY SERVICES				
12. Physical Therapy	5020	195,525	0	195,525
13. Occupational Therapy	5030	82,090	0	82,090
14. Speech Therapy	5040	20,950	0	20,950
15. Audiology Therapy	5050	0	0	0
16. Respiratory Therapy	5060	0	0	0
17. TOTAL (lines 12 through 16)		298,565	0	298,565
MEDICAL SUPPLIES				
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	0	0	0
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	6,269	0	6,269
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	0	0	0
25. Medical Supplies-Routine	5080	0	0	0
26. Habilitation Supplies	5085	0	0	0
27. TOTAL Medical Supplies(lines 18 through 26)		6,269	0	6,269
MEDICAL MINOR EQUIPMENT				
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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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
ENTERAL NUTRITION THERAPY				
37. Medicare B - Medicaid (To Sch. A-2, Line 3a, Col. 2)	5110-1	126	0	126
38. Medicare B - Other(To Sch. A-2, Line 3a, Col. 3)	5110-2	293	0	293
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)		419	0	419
OTHER ANCILLARY SERVICE				
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
OTHER SERVICES				
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	0	0	0
56. Laboratory	5370	1,609	0	1,609
57. Oxygen	5380	0	0	0
58. Legend Drugs	5390	31,052	0	31,052
59. Other - Specify Below	5400	0	0	0
60. TOTAL Other Services (lines 50 through 59)		32,661	0	32,661

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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

Revenue Account Name	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
NON-OPERATING				
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	35	0	35
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	0	0	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)		35	0	35
81. TOTAL (SUM OF LINES 6, 11, 17, 27, 36, 45, 49, 60 AND 80)		1,330,400	0	1,330,400

ADJUSTMENT TO TRIAL BALANCE

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
---	-------------------------------------	--

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. Marketing Salary		-4,537	-1,134	-5,671	7695	
2. Offset WC Interest		0	-35	-35	7665	
3. Book/CR Depr Equip		0	-18	-18	8040	
4. Book/CR Home Office Depr		0	-739	-739	8090	
5. Home Office Depr/MH		0	-1,854	-1,854	8090	
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	-126	-126	7055	
9. A-2 Offset (Line 12, Col 5)		0	-37	-37	7690	
10. TOTAL		-4,537	-3,943	-8,480		

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Provider Name	Medicaid Provider Number	Reporting Period
MORNING VIEW CARE CENTER OF MARION	0001910	From 1/1/2005 Through: 12/31/2005

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, 2005
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	Medicaid Provider Number	Reporting Period
MORNING VIEW CARE CENTER OF MARION	0001910	From: 1/1/2005 Through: 12/31/2005

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

100.00

NURSE AIDE TRAINING STATISTICAL INFORMATION

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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.	1	3	0	0	4

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.	4	0	0	0	4
3. Number of aides who dropped out of training during the cost report period.	5	0	0	0	5
4. Total aides (sum of lines 2 and 3)	9	0	0	0	9
5. Total number of state approved nurse aides on your payroll at the end of the cost report period.					16
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)(1)(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: 1/1/2005 Through: 12/31/2005
---	-------------------------------------	--

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)
DIRECT CARE NURSING AND HABILITATION/REHABILITATION							
1. Medical Director	6100	0	0	0	0	0	0
2. Director of Nursing	6105	55,265	0	55,265	2,085	0	2,085
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	109,005	0	109,005	5,089	0	5,089
6. Licensed Practical Nurse	6125	110,597	0	110,597	6,000	0	6,000
7. Nurse Aides	6130	159,267	0	159,267	17,955	0	17,955
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
14. Qualified Mental Retardation Professional	6240	0	0	0	0	0	0
15. Program Director	6250	0	0	0	0	0	0
16. Habilitation Supervisor	6260	0	0	0	0	0	0
17. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 16)		434,134	0	434,134	31,129	0	31,129
NURSE AIDE TRAINING							
18. In-House Trainer Wages	6500	1,793	0	1,793	101	0	101
19. Classroom Wages: Nurse Aides	6511	4,267	0	4,267	600	0	600
20. Clinical Wages: Nurse Aides	6521	420	0	420	59	0	59
21. TOTAL Nurse Aide Training (sum of lines 18 through 20)		6,480	0	6,480	760	0	760
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - DIRECT CARE							
22. EAP Administrator - Direct Care	6730	0	0	0	0	0	0
23. Self Funded Programs Administrator - Direct Care	6740	0	0	0	0	0	0
24. Staff Development - Direct Care	6750	0	0	0	0	0	0
25. TOTAL Payroll Tax, Fringe Benefits, and Staff Development (sum of lines 22 through 24)		0	0	0	0	0	0
26. TOTAL Page 1(sum of lines 17, 21 and 25)		440,614	0	440,614	31,889	0	31,889

WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
MORNING VIEW CARE CENTER OF MARION		0001910		From: 1/1/2005		Through: 12/31/2005	
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)
ANCILLARY/SUPPORT DIETARY COST							
27. Dietitian	7000	12,923	0	12,923	451	0	451
28. Food Service Supervisor	7005	21,079	0	21,079	2,164	0	2,164
29. Dietary Personnel	7015	27,482	0	27,482	3,188	0	3,188
30. EAP Administrator - Dietary	7075	0	0	0	0	0	0
31. Self Funded Programs Admin. - Dietary	7080	0	0	0	0	0	0
32. Staff Development - Dietary	7090	0	0	0	0	0	0
33. TOTAL Dietary (sum of lines 27 through 32)		61,484	0	61,484	5,803	0	5,803
HABILITATION AND PHARMACEUTICAL							
34. Medical/Habilitation Records	7105	0	0	0	0	0	0
35. Pharmaceutical Consultant	7110	0	0	0	0	0	0
36. TOTAL Habilitation, Pharmaceutical(sum of lines 34 & 35)		0	0	0	0	0	0
ACTIVITIES, HABILITATION, AND SOCIAL SERVICES							
37. Activity Director	7201	23,937	0	23,937	2,172	0	2,172
38. Activity Staff	7211	2,529	0	2,529	237	0	237
39. Recreational Therapist	7221	0	0	0	0	0	0
40. Psychologist	7231	0	0	0	0	0	0
41. Psychology Assistant	7241	0	0	0	0	0	0
42. Social Work/Counseling	7251	0	0	0	0	0	0
43. Social Services/Pastoral Care	7261	0	0	0	0	0	0
44. TOTAL Activities, Habilitation, and Social Services (sum of lines 37 through 43)		26,466	0	26,466	2,409	0	2,409
UTILITIES							
45. Water and Sewage (salary only)	7511	326	0	326	24	0	24
ADMINISTRATIVE & GENERAL SERVICES							
46. Administrator	7600	0	0	0	0	0	0
47. Other Administrative Personnel	7605	20,949	20,949	0	546	546	0
48. Security Services (salary only)	7625	0	0	0	0	0	0
49. Laundry/Housekeeping Supervisor	7635	25,081	0	25,081	2,074	0	2,074
50. Housekeeping	7640	3,320	0	3,320	376	0	376
51. Laundry and Linen	7645	13,379	0	13,379	1,610	0	1,610
52. Accounting	7655	22,617	0	22,617	2,014	0	2,014
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	37,100	0	37,100	1,160	0	1,160
56. TOTAL Admin. & General Services(sum of lines 46 thru 55)		122,446	20,949	101,497	7,780	546	7,234
MAINTENANCE PERSONNEL							
57. Plant Operations Maintenance Supervisor	7700	4,060	0	4,060	198	0	198
58. Plant Operations and Maintenance	7710	10,772	0	10,772	804	0	804
59. TOTAL Maintenance Personnel(sum of lines 57 and 58)		14,832	0	14,832	1,002	0	1,002
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - ANCILLARY/SUPPORT							
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
63. TOTAL Payroll Taxes, Fringe Benefits, & Staff Development - Ancillary/Support (sum of lines 60 thru 62)		0	0	0	0	0	0
64. TOTAL Page 2(sum of lines 33, 36, 44, 45, 56, 59 and 63)		225,554	20,949	204,605	17,018	546	16,472
65. TOTAL Attachment 6 Pages 1 and 2 (sum of lines 26 & 64)		666,168	20,949	645,219	48,907	546	48,361

ADDENDUM FOR DISPUTED COSTS

Provider Name MORNING VIEW CARE CENTER OF MARION	Medicaid Provider Number 0001910	Reporting Period From: 01/01/2005 Through: 12/31/2005
---	-------------------------------------	--

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)
TAX COSTS							
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			
DIRECT CARE COSTS							
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			
ANICLLARY/SUPPORT COSTS							
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			
NON-REIMBURSABLE EXPENSES							
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			
CAPITAL COSTS							
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	Medicaid Provider Number	Reporting Period	
MORNING VIEW CARE CENTER OF MARION	0001910	From: 01/01/2005	Through: 12/31/2005

- | | |
|--|-----------|
| 1. Number of FTEs on first full payroll ending date of the cost reporting period | 24.21 |
| 2. Number of FTEs on last payroll ending date of the cost reporting period remaining from line 1 | 12.15 |
| 3. Employee Retention Rate ((Line 2 divided by line 1)*100%) | 50.1859 % |