

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0027979

Facility Name: MONMOUTH NURSING HOME

Address: 117 SOUTH I STREET MONMOUTH 61462
 Number City Zip Code

County: WARREN

Telephone Number: 309-734-3811 Fax # ()

HFS ID Number: 0027979

Date of Initial License for Current Owners: 11/11/83

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/05 to 9/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JAMES J GIARDINA</u>	
	(Title) <u>PRESIDENT</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL E BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>PO BOX 1190; SPRINGFIELD, MO 65801</u>	
	(Telephone) <u>417-865-8701</u> Fax # <u>417-865-0682</u>	

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

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/05 Ending: 9/30/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>59</u>	Skilled (SNF)	<u>59</u>	<u>21,535</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>59</u>	TOTALS	<u>59</u>	<u>21,535</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,740</u>	<u>7,255</u>	<u>2,754</u>	<u>18,749</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,740</u>	<u>7,255</u>	<u>2,754</u>	<u>18,749</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.06%

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

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

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

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

N/AF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 11/11/83

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/11/83 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 59 and days of care provided 1,639Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 9/30/06 Fiscal Year: 9/30/06

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

Facility Name & ID Number **MONMOUTH NURSING HOME** # **0027979** Report Period Beginning: **10/1/05** Ending: **9/30/06**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	110,003	9,543	4,115	123,661		123,661		123,661		1
2	Food Purchase		91,257		91,257		91,257	(5,430)	85,827		2
3	Housekeeping	92,417	11,409		103,826		103,826	149	103,975		3
4	Laundry	34,606	15,683		50,289		50,289		50,289		4
5	Heat and Other Utilities			60,100	60,100		60,100		60,100		5
6	Maintenance	20,724	16,811	18,023	55,558		55,558	254	55,812		6
7	Other (specify):*										7
8	TOTAL General Services	257,750	144,703	82,238	484,691		484,691	(5,027)	479,664		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	748,858	88,582	2,325	839,765		839,765	1,527	841,292		10
10a	Therapy		732	114,396	115,128		115,128		115,128		10a
11	Activities	21,513	408	5,285	27,206		27,206		27,206		11
12	Social Services	25,721		1,650	27,371		27,371		27,371		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	796,092	89,722	129,056	1,014,870		1,014,870	1,527	1,016,397		16
	C. General Administration										
17	Administrative	59,594			59,594		59,594	8,020	67,614		17
18	Directors Fees										18
19	Professional Services			80,180	80,180		80,180	(66,994)	13,186		19
20	Dues, Fees, Subscriptions & Promotions			16,071	16,071		16,071	(11,287)	4,784		20
21	Clerical & General Office Expenses	23,608	6,902	17,626	48,136		48,136	38,980	87,116		21
22	Employee Benefits & Payroll Taxes			214,866	214,866		214,866	(452)	214,414		22
23	Inservice Training & Education			1,895	1,895		1,895		1,895		23
24	Travel and Seminar			2,209	2,209		2,209	3,435	5,644		24
25	Other Admin. Staff Transportation							181	181		25
26	Insurance-Prop.Liab.Malpractice			42,119	42,119		42,119	39	42,158		26
27	Other (specify):*										27
28	TOTAL General Administration	83,202	6,902	374,966	465,070		465,070	(28,078)	436,992		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,137,044	241,327	586,260	1,964,631		1,964,631	(31,578)	1,933,053		29

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

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

Facility Name & ID Number MONMOUTH NURSING HOME

#0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			51,156	51,156		51,156	30,803	81,959			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			13,325	13,325		13,325	46,767	60,092			32
33	Real Estate Taxes			43,324	43,324		43,324		43,324			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(186,501)	8,199			34
35	Rent-Equipment & Vehicles			915	915		915	1,875	2,790			35
36	Other (specify):*											36
37	TOTAL Ownership			303,420	303,420		303,420	(106,888)	196,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,303	32,303		32,303		32,303			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,303	32,303		32,303		32,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,137,044	241,327	921,983	2,300,354		2,300,354	(138,466)	2,161,888			45

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/1/05

Ending: 9/30/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,021)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,199	30		9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(409)	2		13
14	Non-Care Related Interest	(12,967)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(71)	21		18
19	Entertainment	(451)	24		19
20	Contributions	(1,742)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,710)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,705)	20		28
29	Other-Attach Schedule	(7,544)	21, 22		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,467)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(101,999)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (101,999)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (138,466)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		6,212	10.2	42
43	Prescription Drugs	X		53,521	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 59,733		47

BHF USE ONLY						
48		49		50		51
						52

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/1/05

Ending: 9/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	MISC INCOME - VENDING MACH	\$ (600)	21
2	MISC INCOME - HEALTH INS	(6,944)	22
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(7,544)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,430)	0	0	0	0	0	0	0	0	0	0	(5,430)	2
3	Housekeeping	0	0	149	0	0	0	0	0	0	0	0	149	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	254	0	0	0	0	0	0	0	0	254	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,430)	0	403	0	(5,027)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,527	0	0	0	0	0	0	0	0	0	1,527	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	1,527	0	1,527	16								
	C. General Administration													
17	Administrative	0	8,020	0	0	0	0	0	0	0	0	0	8,020	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(66,994)	0	0	0	0	0	0	0	0	0	(66,994)	19
20	Fees, Subscriptions & Promotions	(11,415)	0	128	0	0	0	0	0	0	0	0	(11,287)	20
21	Clerical & General Office Expenses	(2,413)	41,393	0	0	0	0	0	0	0	0	0	38,980	21
22	Employee Benefits & Payroll Taxes	(6,944)	6,492	0	0	0	0	0	0	0	0	0	(452)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(451)	3,886	0	0	0	0	0	0	0	0	0	3,435	24
25	Other Admin. Staff Transportation	0	0	181	0	0	0	0	0	0	0	0	181	25
26	Insurance-Prop.Liab.Malpractice	0	0	39	0	0	0	0	0	0	0	0	39	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(21,223)	(7,203)	348	0	(28,078)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,653)	(5,676)	751	0	(31,578)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	3,199	27,604	0	0	0	0	0	0	0	0	0	30,803	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(13,013)	59,780	0	0	0	0	0	0	0	0	0	46,767	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(186,501)	0	0	0	0	0	0	0	0	0	(186,501)	34
35	Rent-Equipment & Vehicles	0	1,875	0	0	0	0	0	0	0	0	0	1,875	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,814)	(97,074)	0	0	0	0	0	0	0	0	0	(106,888)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,467)	(102,750)	751	0	(138,466)	45							

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	MAR-KA NURSING HOME	MASCOUTAH	COMMUNITY CARE CTRS, INC	BALLWIN, MO	HOME OFFICE
				RISA	JEFFERSON CITY, MO	W/C INS
				RISA	JEFFERSON CITY, MO	LIAB INS

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 BUILDING RENT	\$ 194,700	JAMES J GIARDINA	100.00%	\$	\$ (194,700)	1
2	V	30 DEPRECIATION		JAMES J GIARDINA	100.00%	27,604	27,604	2
3	V	32 INTEREST		JAMES J GIARDINA	100.00%	59,780	59,780	3
4	V	31 AMORTIZATION		JAMES J GIARDINA	100.00%	168	168	4
5	V	19 HOME OFFICE/MGMT FEES	69,600	COMMUNITY CARE CENTERS, INC	100.00%		(69,600)	5
6	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	8,199	8,199	6
7	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	1,875	1,875	7
8	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	1,527	1,527	8
9	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	8,020	8,020	9
10	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	41,393	41,393	10
11	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	6,492	6,492	11
12	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	2,606	2,606	12
13	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	3,886	3,886	13
14	Total		\$ 264,300			\$ 161,550	\$ * (102,750)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	25	HOME OFFICE/MGMT FEES	\$	COMMUNITY CARE CENTERS, INC	100.00%	\$ 181	\$ 181	15	
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	254	254	16	
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	128	128	17	
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	39	39	18	
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	100.00%	149	149	19	
20	V	22	WORKERS COMP INSURANCE	72,242	RISA	25.00%	72,242		20	
21	V	26	LIABILITY INSURANCE	35,219	RISA	25.00%	35,219		21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 107,461			\$ 108,212	\$ *	751	39

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/05 Ending: 9/30/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JAMES J GIARDINA	PRESIDENT	GEN DIRECTOR	100.00		3	6.00	SALARY	\$ 4,935	17.7	1
2	BETTY HUGHES	SECRETARY		0.00		2	4.76	SALARY	3,085	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,020		13

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

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/1/05

Ending: 9/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization COMMUNITY CARE CENTERS, INC
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63021
 Phone Number (636-394-3000
 Fax Number (636-394-7713

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE							1
2		WEST COUNTY CARE CENTER					5,339,306	204,067	2
3		ST GENEVIEVE CARE CTR					2,307,399	81,166	3
4		CCC OF LEMAY					2,208,017	87,857	4
5		SALEM CARE CENTER					1,747,427	62,309	5
6		MONMOUTH NH					2,230,753	74,900	6
7		MAR-KA NH					2,918,424	117,035	7
8		CCC OF SENECA					2,546,190	84,943	8
9		MT VERNON PLACE CARE					2,569,979	88,419	9
10		COUNTRY VIEW NH					2,015,154	74,562	10
11		MERAMEC NH					2,636,073	118,530	11
12		SEVILLE CARE CENTER					2,768,251	93,570	12
13		SALEM RES CARE					533,663	17,467	13
14		BOSS RES CARE					44,419	1,454	14
15		CARL JUNCTION RES CARE					614,100	20,100	15
16		MT VERNON RES CARE					504,072	16,499	16
17		SENECA HOME PLACE					459,406	15,037	17
18		HUDSON HOUSE					518,315	16,965	18
19		MAPLE GROVE LODGE					2,667,783	135,970	19
20		CCC OF AURORA					4,223,776	140,398	20
21		BARRY COMMUNITY CARE					2,498,209	85,523	21
22		LICKING RESIDENTIAL CTR					383,431	12,550	22
23		CCC OF GAINESVILLE					421,218	19,164	23
24		COMMUNITY IN HOME					790,625	25,878	24
25	TOTALS							1,594,363	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DUE TO SHAREHOLDERS	X									10,800	6
7	DUE RELATED PARTY	X									2,167	7
8	LOWES		X	CARPET							358	8
9	TOTAL Facility Related						\$	\$			\$ 13,325	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$ 13,325	15

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONMOUTH NURSING HOME COUNTY WARREN

FACILITY IDPH LICENSE NUMBER 0027979

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-532-008-00</u>	<u>LOTS 6, 7, 9, 10 & 11 BLOCK 2</u>	\$ <u>39,205.00</u>	\$ <u>39,205.00</u>
2. _____	<u>SUNSET VIEW ADDN</u>	\$ _____	\$ _____
3. <u>09-393-001-00</u>	<u>63.43' N END W PT BLOCK 3</u>	\$ <u>127.00</u>	\$ <u>127.00</u>
4. _____	<u>WEST PARD ADDN</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>39,332.00</u>	\$ <u>39,332.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning:

10/1/05 Ending:

9/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,000 B. General Construction Type: Exterior BRICK VENEER Frame FRAME Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		50,094	1983	\$ 12,180	1
2			1990	7,500	2
3	TOTALS	50,094		\$ 19,680	3

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	35		1983	1959	\$ 415,462	\$	10-20	\$ 7,500	\$ 7,500	\$ 467,845	4
5	19			1990	653,401		3-30	20,104	20,104	385,351	5
6											6
7											7
8											8
	Improvement Type**										
9		DRAPERY AND CUBICAL		1991	4,570		10			4,570	9
10		ROOF REPAIRS		1992	3,181		10			3,181	10
11		CARPETING		1992	4,074		5			4,074	11
12		CARPETING		1993	4,411		5			4,411	12
13		ROOF REPAIRS		1996	1,380		10			1,380	13
14		ALARM		1997	7,078		15			7,078	14
15		NURSE CALL SYSTEM		2000	7,347		10			7,347	15
16		FIRE ALARM SYSTEM		2001	2,587		10			2,587	16
17		HOT WATER HEATER		2001	2,712		10			2,712	17
18		DOOR		2002	5,112		20			5,112	18
19		BLACKTOP DRIVEWAYS		2002	8,651		8			8,651	19
20		MIXING VALVE ON WATER		2002	987		20			987	20
21		NEW ROOF COURT YD/RM 46		2002	917		10			917	21
22		FIXTURES		2002	3,231		10			3,231	22
23		ROOF OVER KITCHEN		2002	9,892		10			9,892	23
24		WHIRLPOOL TUB		2003	10,829		10			10,829	24
25		GUTTERS		2003	1,000		10			1,000	25
26		RACKS FOR ROOMS		2003	1,526		10			1,526	26
27		WATER HEATER		2003	2,022		10			2,022	27
28		SIDEWALKS		2004	1,350		15			1,350	28
29		EAST SIDEWALKS		2004	1,200		15			1,200	29
30		HOPPER		2004	3,274		20			3,274	30
31		4 VINYL WINDOWS		2004	1,153	494	Life of Lease	494		1,029	31
32		NEW CARPETING & SUBFLOOR		2005	20,011	10,006	Life of Lease	10,006		17,510	32
33		SMOKE DAMPER		2005	1,440	751	Life of Lease	751		1,252	33
34		WANDERGUARD SYSTEM		2005	8,249	4,713	Life of Lease	4,713		7,070	34
35		MAIN ROOF		2005	25,000	19,643	Life of Lease	19,643		19,643	35
36		GRAVEL FOR SIDE PARKING LOT		2006	1,102	689	Life of Lease	689		689	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **MONMOUTH NURSING HOME**

0027979

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38			(3,199)			3,199		38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,213,149	\$ 33,097		\$ 63,900	\$ 30,803	\$ 987,720	70

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/05 Ending: 9/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 184,120	\$ 16,901	\$ 16,901	\$	VARIOUS	\$ 110,289	71
72	Current Year Purchases	7,186	195	195		VARIOUS	195	72
73	Fully Depreciated Assets							73
74	DISPOSALS	(1,925)	963	963			1,925	74
75	TOTALS	\$ 189,381	\$ 18,059	\$ 18,059	\$		\$ 112,409	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 DODGE VAN	2002	\$ 12,000	\$	\$	\$	4	\$ 12,000	76
77										77
78										78
79										79
80	TOTALS			\$ 12,000	\$	\$	\$		\$ 12,000	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	1,434,210	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	51,156	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	81,959	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	30,803	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,112,129	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY LEASE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 915 Description: WATER SOFTENER - 720; TRUCK RENTAL - 195

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	628	\$ 39,446	\$ 215	628	\$ 39,661	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		47	2,825		47	2,825	2
3	Licensed Recreational Therapist		hrs				517		517	3
4	Licensed Physical Therapist	10a.3	hrs		1,063	72,125		1,063	72,125	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,738	\$ 114,396	\$ 732	1,738	\$ 115,128	14

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

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979Report Period Beginning: 10/1/05

Ending:

9/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,247	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,440)	307,160		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,756		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(115,969)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 244,194	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	135,801		15
16	Equipment, at Historical Cost	201,381		16
17	Accumulated Depreciation (book methods)	(245,819)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	11,251		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 104,114	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 348,308	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,459	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,124		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,180		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,700		32
33	Accrued Interest Payable	18,400		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	352,350		36
37	PATIENT FUNDS/DUE TO MCR	9,859		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 549,072	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 549,072	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (200,764)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 348,308	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (85,273)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (85,273)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(67,260)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PRIOR YEAR ADJS - DEPR EXP	(48,231)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (115,491)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (200,764)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/1/05

Ending: 9/30/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,819,650	1
2	Discounts and Allowances for all Levels	(8,025,408)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,794,242	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,590	6
7	Oxygen	142,651	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 426,241	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,021	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,021	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME - VENDING MACH	600	28
28a	MISCELLANEOUS INCOME - HEALTH INS	6,944	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,544	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,233,094	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	484,691	31
32	Health Care	1,014,870	32
33	General Administration	465,070	33
B. Capital Expense			
34	Ownership	303,420	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	32,303	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,300,354	40
41	Income before Income Taxes (line 30 minus line 40)**	(67,260)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (67,260)	43

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

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

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

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

Facility Name & ID Number **MONMOUTH NURSING HOME**

0027979

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10/1/05

Ending:

9/30/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,968	2,080	\$ 42,550	\$ 20.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,289	4,749	78,995	16.63	3
4	Licensed Practical Nurses	13,355	14,603	205,094	14.04	4
5	CNAs & Orderlies	47,979	51,972	422,219	8.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,963	2,157	21,513	9.97	9
10	Activity Assistants					10
11	Social Service Workers	1,978	2,204	25,721	11.67	11
12	Dietician					12
13	Food Service Supervisor	1,765	1,813	17,645	9.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,514	5,951	42,380	7.12	15
16	Dishwashers	6,083	6,629	49,978	7.54	16
17	Maintenance Workers	1,883	2,087	20,724	9.93	17
18	Housekeepers	11,274	12,352	92,417	7.48	18
19	Laundry	4,359	4,497	34,606	7.70	19
20	Administrator	1,904	2,080	59,594	28.65	20
21	Assistant Administrator					21
22	Other Administrative	1,921	2,131	23,608	11.08	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,235	115,305	\$ 1,137,044 *	\$ 9.86	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 4,115	1.3	35
36	Medical Director	96	5,400	9.3	36
37	Medical Records Consultant	24	1,125	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	90	1,200	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,650	11.3	44
45	Social Service Consultant	24	1,650	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	354	\$ 15,140		49

C. CONTRACT NURSES

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

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0027979

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
JOYCE JUERGENS	ADMINISTRATOR	0	\$ 59,594	Workers' Compensation Insurance	\$ 72,242	IDPH License Fee	\$			
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	70			
				FICA Taxes	104,772	Health Care Worker Background Check				
				Employee Health Insurance	32,523	(Indicate # of checks performed <u>20</u>)	200			
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	2,390			
				OTHER EMPLOYEE BENEFITS	3,641	TAXES & LICENSES	1,996			
				401K CONTRIBUTIONS	1,688	ADVERTISING OTHER	11,415			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 59,594	TOTAL (agree to Schedule V, line 22, col.8)			\$ 214,414	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,784
(List each licensed administrator separately.)				HOME OFFICE ALLOCATION			6,492	Less: Public Relations Expense		()
B. Administrative - Other				SCH VI OFFSET OF HEALTH INS			(6,944)	Non-allowable advertising		(9,710)
Description				Amount			Yellow page advertising		(1,705)	
NONE										
TOTAL (agree to Schedule V, line 17, col. 3)										
(Attach a copy of any management service agreement)										
C. Professional Services			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount			
COMMUNITY CARE CENTERS, INC	MGMT FEES	69,600	NONE			Out-of-State Travel	\$			
BKD, LLP	ACCOUNTING	10,580				In-State Travel	1,758			
						MEALS	451			
						Seminar Expense				
						HOME OFFICE ALLOCATION	3,886			
						Entertainment Expense	(451)			
TOTAL (agree to Schedule V, line 19, column 3)			TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 5,644		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,180							

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MONMOUTH NURSING HOME

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL HEALTH CARE ASSOC \$3,257
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 3-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 189 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,303
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation. TRAVEL TO/FROM HOME OFFICE/SEMINAR
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 8%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: BKD, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. TO BE SENT WHEN COMPLETION
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.