

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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
<b>IRS Exemption Code</b> _____	<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 10/01/06 to 9/30/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JAMES J. GIARDINA</u>	
	(Title) <u>PRESIDENT</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>DARRYL E. BUEKER, CPA</u>	
	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. 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: 10/01/06 Ending: 9/30/07

## 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>9,708</u>	<u>5,401</u>	<u>2,451</u>	<u>17,560</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,708</u>	<u>5,401</u>	<u>2,451</u>	<u>17,560</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.54%

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

1 (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 &amp; 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 1,433Medicare Intermediary NGS (ADMINISTAR FEDERAL)

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 930/07 Fiscal Year: 9/30/07

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

Facility Name & ID Number **MONMOUTH NURSING HOME** # **0027979** Report Period Beginning: **10/01/06** Ending: **9/30/07**

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	99,852	7,855	4,115	111,822		111,822		111,822		1
2	Food Purchase		87,945		87,945		87,945	(6,585)	81,360		2
3	Housekeeping	102,034	12,988		115,022		115,022	137	115,159		3
4	Laundry	34,905	14,545		49,450		49,450		49,450		4
5	Heat and Other Utilities			67,397	67,397		67,397		67,397		5
6	Maintenance	21,535	14,563	49,897	85,995		85,995	278	86,273		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>258,326</b>	<b>137,896</b>	<b>121,409</b>	<b>517,631</b>		<b>517,631</b>	<b>(6,170)</b>	<b>511,461</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	739,295	86,770	1,101	827,166		827,166	2,879	830,045		10
10a	Therapy		247	123,585	123,832		123,832		123,832		10a
11	Activities	27,089	349	4,638	32,076		32,076		32,076		11
12	Social Services	30,359		1,500	31,859		31,859		31,859		12
13	CNA Training		83		83		83		83		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>796,743</b>	<b>87,449</b>	<b>136,224</b>	<b>1,020,416</b>		<b>1,020,416</b>	<b>2,879</b>	<b>1,023,295</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	61,605			61,605		61,605	7,524	69,129		17
18	Directors Fees										18
19	Professional Services			81,598	81,598		81,598	(67,832)	13,766		19
20	Dues, Fees, Subscriptions & Promotions			18,215	18,215		18,215	(11,130)	7,085		20
21	Clerical & General Office Expenses	39,375	7,257	18,835	65,467		65,467	39,847	105,314		21
22	Employee Benefits & Payroll Taxes			185,978	185,978		185,978	5,454	191,432		22
23	Inservice Training & Education			1,136	1,136		1,136		1,136		23
24	Travel and Seminar			3,212	3,212		3,212	2,600	5,812		24
25	Other Admin. Staff Transportation							291	291		25
26	Insurance-Prop.Liab.Malpractice			41,452	41,452		41,452	36	41,488		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>100,980</b>	<b>7,257</b>	<b>350,426</b>	<b>458,663</b>		<b>458,663</b>	<b>(23,210)</b>	<b>435,453</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,156,049</b>	<b>232,602</b>	<b>608,059</b>	<b>1,996,710</b>		<b>1,996,710</b>	<b>(26,501)</b>	<b>1,970,209</b>		<b>29</b>

\*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:

10/01/06

Ending:

9/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			26,717	26,717		26,717	27,604	54,321			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			18,106	18,106		18,106	36,511	54,617			32
33	Real Estate Taxes			40,210	40,210		40,210		40,210			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(186,788)	7,912			34
35	Rent-Equipment & Vehicles			720	720		720	2,271	2,991			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			280,453	280,453		280,453	(120,234)	160,219			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>			32,303	32,303		32,303		32,303			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,156,049	232,602	920,815	2,309,466		2,309,466	(146,735)	2,162,731			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: 10/01/06

Ending: 9/30/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,426)	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				9
10	Interest and Other Investment Income	(932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(159)	2		13
14	Non-Care Related Interest	(18,106)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(307)	24		19
20	Contributions	(1,525)	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	(11,210)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,201)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (41,866)		\$	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)	(104,869)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (104,869)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (146,735)		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.			\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		2,714	10.2	42
43	Prescription Drugs	X		51,774	10.2	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 54,488		47

BHF USE ONLY						
48		49		50		51
						52

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/01/06

Ending: 9/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME-TRAVEL	\$ (9)	21	1
2	MISC INCOME-HEALTH INS	(2,334)	22	2
3	MISC INCOME-VOIDED CHECKS	(1,148)	21	3
4	MISC INCOME-RESIDENT SALES	290	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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	<b>Total</b>	(3,201)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/01/06

Ending:

9/30/07

**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,585)	0	0	0	0	0	0	0	0	0	0	(6,585)	2
3	Housekeeping	0	0	137	0	0	0	0	0	0	0	0	137	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	278	0	0	0	0	0	0	0	0	278	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(6,585)</b>	<b>0</b>	<b>415</b>	<b>0</b>	<b>(6,170)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,879	0	0	0	0	0	0	0	0	0	2,879	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>2,879</b>	<b>0</b>	<b>2,879</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	7,524	0	0	0	0	0	0	0	0	0	7,524	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(67,832)	0	0	0	0	0	0	0	0	0	(67,832)	19
20	Fees, Subscriptions & Promotions	(11,210)	0	80	0	0	0	0	0	0	0	0	(11,130)	20
21	Clerical & General Office Expenses	(2,392)	42,239	0	0	0	0	0	0	0	0	0	39,847	21
22	Employee Benefits & Payroll Taxes	(2,334)	7,788	0	0	0	0	0	0	0	0	0	5,454	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(307)	2,907	0	0	0	0	0	0	0	0	0	2,600	24
25	Other Admin. Staff Transportation	0	0	291	0	0	0	0	0	0	0	0	291	25
26	Insurance-Prop.Liab.Malpractice	0	0	36	0	0	0	0	0	0	0	0	36	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(16,243)</b>	<b>(7,374)</b>	<b>407</b>	<b>0</b>	<b>(23,210)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(22,828)</b>	<b>(4,495)</b>	<b>822</b>	<b>0</b>	<b>(26,501)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME

# 0027979

Report Period Beginning:

10/01/06 Ending:

9/30/07

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	0	27,604	0	0	0	0	0	0	0	0	0	27,604	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(19,038)	55,549	0	0	0	0	0	0	0	0	0	36,511	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(186,788)	0	0	0	0	0	0	0	0	0	(186,788)	34
35	Rent-Equipment & Vehicles	0	2,271	0	0	0	0	0	0	0	0	0	2,271	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,038)</b>	<b>(101,196)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(120,234)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(41,866)</b>	<b>(105,691)</b>	<b>822</b>	<b>0</b>	<b>(146,735)</b>	<b>45</b>							

Facility Name & ID Number MONMOUTH NURSING HOME

# 0027979

Report Period Beginning:

10/01/06

Ending:

9/30/07

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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%	55,549	55,549	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%	7,912	7,912	6
7	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,271	2,271	7
8	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,879	2,879	8
9	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	7,524	7,524	9
10	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	42,239	42,239	10
11	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	7,788	7,788	11
12	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	1,768	1,768	12
13	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	2,907	2,907	13
14	Total		\$ 264,300			\$ 158,609	\$ * (105,691)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	\$ 291	\$ 291	15	
16	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	278	278	16	
17	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	80	80	17	
18	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	36	36	18	
19	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	137	137	19	
20	V	22 WORKERS COMP INSURANCE	42,625	RISA	25.00%	42,625		20	
21	V	26 LIABILITY INSURANCE	35,400	RISA	25.00%	35,400		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		\$ 78,025			\$ 78,847	\$ *	822	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: 10/01/06 Ending: 9/30/07

## 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		2	4.00	SALARY	\$ 4,524	17.7	1
2	BETTY HUGHES	SECRETARY				2	5.00		3,001	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	\$ 7,525		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: 10/01/06

Ending: 9/30/07

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	DIRECT COST		\$	\$		\$	1
2		WEST COUNTY CARE CENTER					5,307,567	199,300	2
3		ST GENEVIEVE CARE CTR					2,545,616	85,525	3
4		CCC OF LEMAY					2,462,676	92,005	4
5		SALEM CARE CENTER					1,293,013	43,955	5
6		MONMOUTH NH					2,239,866	76,110	6
7		MAR-KA NH					2,984,003	123,268	7
8		CCC OF SENECA					2,816,361	98,724	8
9		MT VERNON PLACE CARE					2,686,003	94,127	9
10		COUNTRY VIEW NH					2,150,970	119,977	10
11		MERAMEC NH					2,640,508	106,172	11
12		SEVILLE CARE CENTER					2,871,893	95,358	12
13		SALEM RES CARE					576,113	18,714	13
14		CARL JUNCTION RES CARE					655,589	21,297	14
15		MT VERNON RES CARE					516,335	16,772	15
16		SENECA HOME PLACE					510,546	16,586	16
17		HUDSON HOUSE					530,685	17,240	17
18		MAPLE GROVE LODGE					2,856,567	115,680	18
19		CCC OF AURORA					4,674,522	152,364	19
20		BARRY COMMUNITY CARE					2,709,134	90,071	20
21		LICKING RESIDENTIAL CTR					402,131	13,062	21
22		CCC OF GAINESVILLE					2,415,594	83,792	22
23		AL OF SILVER CREEK					342,585	11,646	23
24		COMMUNITY IN HOME					846,367	27,647	24
25	TOTALS				\$	\$		\$ 1,719,392	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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	<b>DUE TO SHAREHOLDERS</b>	<b>X</b>									<b>17,325</b>	<b>6</b>
7	<b>DUE RELATED PARTY</b>	<b>X</b>									<b>781</b>	<b>7</b>
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$ <b>18,106</b>	<b>9</b>
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	<b>14</b>
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ <b>18,106</b>	<b>15</b>

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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 &amp; 11 BLOCK 2</u>	\$ <u>39,741.26</u>	\$ <u>39,741.26</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>108.92</u>	\$ <u>108.92</u>
4. _____	<u>WEST PARD ADDN</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>39,850.18</u>	\$ <u>39,850.18</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

10/01/06 Ending:

9/30/07

**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).

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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 &amp; ID Number MONMOUTH NURSING HOME

# 0027979

Report Period Beginning:

10/01/06

Ending:

9/30/07

**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	\$ 475,345	4
5	19			1990	653,401		3-30	20,104	20,104	405,455	5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
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											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	123	Life of Lease	124	1	1,153	31
32		NEW CARPETING & SUBFLOOR		2005	20,011	2,501	Life of Lease	2,501		20,011	32
33		SMOKE DAMPER		2005	1,440	188	Life of Lease	188		1,440	33
34		WANDERGUARD SYSTEM		2005	8,249	1,178	Life of Lease	1,178		8,249	34
35		MAIN ROOF		2005	25,000	5,357	Life of Lease	5,357		25,000	35
36		GRAVEL FOR SIDE PARKING LOT		2006	1,102	413	Life of Lease	413		1,102	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:

10/01/06

Ending:

9/30/07

**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 <b>COURTYARD ROOF</b>	<b>2007</b>	\$ <b>1,178</b>	\$ <b>269</b>	<b>Life of Lease</b>	\$ <b>269</b>	\$	\$ <b>269</b>	37
38								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 <b>TOTAL (lines 4 thru 69)</b>		\$ <b>1,213,410</b>	\$ <b>10,029</b>		\$ <b>37,634</b>	\$ <b>27,605</b>	\$ <b>1,024,438</b>	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: 10/01/06 Ending: 9/30/07

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	\$ 187,664	\$ 15,475	\$ 15,475	\$		\$ 122,615	71
72	Current Year Purchases	10,646	1,212	1,212			1,212	72
73	Fully Depreciated Assets							73
74	DISPOSALS	(917)					2,634	74
75	TOTALS	\$ 197,393	\$ 16,687	\$ 16,687	\$		\$ 126,461	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)		\$ 1,442,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 26,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 54,321	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 27,605	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,162,899	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: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 720

Description: WATER SOFTENER

(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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/01/06 Ending: 9/30/07

**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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>85</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>42</u></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		83		83
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	\$	\$ 83	\$	\$ 83
10	SUM OF line 9, col. 1 and 2 (e)	\$	83		

**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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

- (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	\$	725	\$ 47,766	\$ 118	725	\$ 47,884	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		137	8,560	43	137	8,603	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		970	67,258	86	970	67,344	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	<b>TOTAL</b>			\$	1,832	\$ 123,584	\$ 247	1,832	\$ 123,831	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

# 0027979

Report Period Beginning: 10/01/06

Ending:

9/30/07

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of 9/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 5,873	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>9,440</u> )	376,962		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,494		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(176,938)		8
9	Other(specify): <u>A/R - Medicare</u>	9,410		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 223,801	\$	10
<b>B. Long-Term Assets</b>				
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	136,062		15
16	Equipment, at Historical Cost	209,393		16
17	Accumulated Depreciation (book methods)	(268,985)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 77,970	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 301,771	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 135,435	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,417		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,054		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,060		32
33	Accrued Interest Payable	35,725		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>DUE TO RELATED PARTIES</u>	325,050		36
37	<u>PATIENT FUNDS/DUE TO MCR</u>	62,987		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 669,728	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 669,728	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (367,957)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 301,771	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (200,764)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (200,764)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(167,193)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (167,193)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (367,957)	24 *

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

Facility Name & ID Number MONMOUTH NURSING HOME

# 0027979

Report Period Beginning: 10/01/06

Ending: 9/30/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,658,000	1
2	Discounts and Allowances for all Levels	(7,936,923)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,721,077</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	284,543	6
7	Oxygen	125,594	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 410,137</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	6,426	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 6,426</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	500	24
25	Interest and Other Investment Income***	932	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,432</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS INCOME</b>	<b>3,201</b>	<b>28</b>
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,201</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,142,273</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	517,631	31
32	Health Care	1,020,416	32
33	General Administration	458,663	33
<b>B. Capital Expense</b>			
34	Ownership	280,453	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	32,303	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,309,466</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(167,193)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (167,193)</b>	<b>43</b>

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

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

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

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

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

# **0027979**

Report Period Beginning: **10/01/06**

Ending:

**9/30/07**

**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	1,960	2,080	\$ 44,003	\$ 21.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,128	4,335	78,362	18.08	3
4	Licensed Practical Nurses	13,172	14,451	204,729	14.17	4
5	CNAs & Orderlies	45,457	48,736	412,201	8.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,560	1,740	18,076	10.39	9
10	Activity Assistants	1,051	1,128	9,013	7.99	10
11	Social Service Workers	2,445	2,785	30,359	10.90	11
12	Dietician					12
13	Food Service Supervisor	1,740	1,960	18,782	9.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,517	7,079	57,289	8.09	15
16	Dishwashers	3,181	3,331	23,781	7.14	16
17	Maintenance Workers	1,912	2,096	21,535	10.27	17
18	Housekeepers	12,061	13,499	102,034	7.56	18
19	Laundry	4,080	4,386	34,905	7.96	19
20	Administrator	1,848	2,080	61,605	29.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,554	3,934	39,375	10.01	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	<b>TOTAL (lines 1 - 33)</b>	<b>104,666</b>	<b>113,620</b>	<b>\$ 1,156,049 *</b>	<b>\$ 10.17</b>	<b>34</b>

\* 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				37
38	Nurse Consultant				38
39	Pharmacist Consultant	90	1,101	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	22	1,500	11.3	44
45	Social Service Consultant	22	1,500	12.3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>326</b>	<b>\$ 13,616</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>		<b>\$</b>	<b>53</b>

Facility Name & ID Number MONMOUTH NURSING HOME

# 0027979

Report Period Beginning: 10/01/06

Ending: 9/30/07

**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	\$ 61,605	Workers' Compensation Insurance	\$ 42,625	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	104,413	Health Care Worker Background Check	770	
				Employee Health Insurance	30,489	(Indicate # of checks performed <u>77</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		<b>DUES &amp; SUBSCRIPTIONS</b>	2,908	
				<b>OTHER EMPLOYEE BENEFITS</b>	7,200	<b>TAXES &amp; LICENSES</b>	3,327	
				<b>401K CONTRIBUTIONS</b>	1,251	<b>ADVERTISING OTHER</b>	11,210	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 61,605			<b>HOME OFFICE ALLOCATION</b>	80	
(List each licensed administrator separately.)						Less: Public Relations Expense	( )	
<b>B. Administrative - Other</b>						Non-allowable advertising	(11,210)	
Description			Amount			Yellow page advertising	( )	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
COMMUNITY CARE CENTERS, INC.	MGMT FEES		69,600	NONE			Out-of-State Travel	\$
SIMPSON & HENNENFENT	LEGAL FEES		982				In-State Travel	2,905
ROSENBLUM, GOLDENHER	LEGAL FEES		26				MEALS	307
BKD, LLP	ACCOUNTING FEES		10,990				Seminar Expense	
							<b>HOME OFFICE ALLOCATION</b>	2,907
							Entertainment Expense	(307)
TOTAL (agree to Schedule V, line 19, column 3)			\$ 81,598				(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 5,812

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; 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 \$3,528
- (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. \$ 207 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? 3%  
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 COMPLETED
- (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 \$5,000, 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.