

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	59	Skilled (SNF)	59	21,594	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	59	TOTALS	59	21,594	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	9,409	3,634	2,412	15,455	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,409	3,634	2,412	15,455	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.57%

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/A

F. 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 1,309

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 9/30/08 Fiscal Year: 9/30/08

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

Facility Name & ID Number **MONMOUTH NURSING HOME** # **0027979** Report Period Beginning: **10/01/07** Ending: **9/30/08**

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
	A. General Services										
1	Dietary	115,674	9,829	4,615	130,118		130,118		130,118		1
2	Food Purchase		83,551		83,551		83,551	(8,074)	75,477		2
3	Housekeeping	87,470	13,108		100,578		100,578	120	100,698		3
4	Laundry	45,897	13,031		58,928		58,928		58,928		4
5	Heat and Other Utilities			72,399	72,399		72,399		72,399		5
6	Maintenance	21,947	13,938	31,603	67,488		67,488	157	67,645		6
7	Other (specify):*										7
8	TOTAL General Services	270,988	133,457	108,617	513,062		513,062	(7,797)	505,265		8
	B. Health Care and Programs										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	726,204	67,042	1,426	794,672		794,672	6,573	801,245		10
10a	Therapy		157	100,000	100,157		100,157		100,157		10a
11	Activities	29,164	16	4,772	33,952		33,952		33,952		11
12	Social Services	33,744		1,788	35,532		35,532		35,532		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	789,112	67,215	113,386	969,713		969,713	6,573	976,286		16
	C. General Administration										
17	Administrative	63,400			63,400		63,400	16,865	80,265		17
18	Directors Fees										18
19	Professional Services			80,940	80,940		80,940	(64,125)	16,815		19
20	Dues, Fees, Subscriptions & Promotions			11,615	11,615		11,615	(6,098)	5,517		20
21	Clerical & General Office Expenses	25,639	6,399	18,671	50,709		50,709	31,794	82,503		21
22	Employee Benefits & Payroll Taxes			165,068	165,068		165,068	8,590	173,658		22
23	Inservice Training & Education			2,485	2,485		2,485		2,485		23
24	Travel and Seminar			4,556	4,556		4,556	3,851	8,407		24
25	Other Admin. Staff Transportation							239	239		25
26	Insurance-Prop.Liab.Malpractice			31,723	31,723		31,723	31	31,754		26
27	Other (specify):*										27
28	TOTAL General Administration	89,039	6,399	315,058	410,496		410,496	(8,853)	401,643		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,149,139	207,071	537,061	1,893,271		1,893,271	(10,077)	1,883,194		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: 10/01/07 Ending: 9/30/08

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
	D. Ownership										
30	Depreciation			18,022	18,022	18,022	27,200	45,222			30
31	Amortization of Pre-Op. & Org.						168	168			31
32	Interest			16,275	16,275	16,275	34,004	50,279			32
33	Real Estate Taxes			37,057	37,057	37,057		37,057			33
34	Rent-Facility & Grounds			194,700	194,700	194,700	(188,298)	6,402			34
35	Rent-Equipment & Vehicles			831	831	831	2,920	3,751			35
36	Other (specify):*										36
37	TOTAL Ownership			266,885	266,885	266,885	(124,006)	142,879			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			32,392	32,392	32,392		32,392			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			32,392	32,392	32,392		32,392			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,149,139	207,071	836,338	2,192,548	2,192,548	(134,083)	2,058,465			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: 10/01/07

Ending: 9/30/08

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	(7,947)	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	(404)	30		9
10	Interest and Other Investment Income	(2,070)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(127)	2		13
14	Non-Care Related Interest	(16,275)	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	(869)	21		18
19	Entertainment	(55)	24		19
20	Contributions				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	(5,468)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(678)	20		28
29	Other-Attach Schedule	(1,550)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,443)		\$	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)	(98,640)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,640)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (134,083)		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		3,523	10.2	42
43	Prescription Drugs	X		36,944	10.2	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 40,467		47

BHF USE ONLY						
48		49		50		51
						52

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/01/07

Ending: 9/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	VENDING INCOME	\$ (1,500)	21	1
2	MISCELLANEOUS INCOME	(50)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(1,550)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/01/07

Ending:

9/30/08

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	(8,074)	0	0	0	0	0	0	0	0	0	0	(8,074)	2
3	Housekeeping	0	0	120	0	0	0	0	0	0	0	0	120	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	157	0	0	0	0	0	0	0	0	157	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,074)	0	277	0	(7,797)	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	6,573	0	0	0	0	0	0	0	0	0	6,573	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	6,573	0	6,573	16								
	C. General Administration													
17	Administrative	0	16,865	0	0	0	0	0	0	0	0	0	16,865	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(64,125)	0	0	0	0	0	0	0	0	0	(64,125)	19
20	Fees, Subscriptions & Promotions	(6,146)	0	48	0	0	0	0	0	0	0	0	(6,098)	20
21	Clerical & General Office Expenses	(2,419)	34,213	0	0	0	0	0	0	0	0	0	31,794	21
22	Employee Benefits & Payroll Taxes	0	8,590	0	0	0	0	0	0	0	0	0	8,590	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(55)	3,906	0	0	0	0	0	0	0	0	0	3,851	24
25	Other Admin. Staff Transportation	0	0	239	0	0	0	0	0	0	0	0	239	25
26	Insurance-Prop.Liab.Malpractice	0	0	31	0	0	0	0	0	0	0	0	31	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(8,620)	(551)	318	0	(8,853)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,694)	6,022	595	0	(10,077)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/01/07 Ending:

9/30/08

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	(404)	27,604	0	0	0	0	0	0	0	0	0	27,200	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(18,345)	52,349	0	0	0	0	0	0	0	0	0	34,004	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(188,298)	0	0	0	0	0	0	0	0	0	(188,298)	34
35	Rent-Equipment & Vehicles	0	2,920	0	0	0	0	0	0	0	0	0	2,920	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(18,749)	(105,257)	0	0	0	0	0	0	0	0	0	(124,006)	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)	(35,443)	(99,235)	595	0	(134,083)	45							

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/01/07

Ending:

9/30/08

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
<u>JAMES J. GIARDINA</u>	<u>100</u>	<u>MAR-KA NURSING HOME</u>	<u>MASCOUTAH</u>	<u>COMMUNITY CARE CTRS, INC.</u>	<u>BALWIN, MO</u>	<u>HOME OFFICE</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>W/C INS</u>
				<u>RISA</u>	<u>JEFFERSON CITY, MO</u>	<u>LIAB INS</u>

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)
<u>1</u>	<u>V</u>	<u>34 BUILDING RENT</u>	<u>\$ 194,700</u>	<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>\$</u>	<u>\$ (194,700)</u>
<u>2</u>	<u>V</u>	<u>30 DEPRECIATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>27,604</u>	<u>27,604</u>
<u>3</u>	<u>V</u>	<u>32 INTEREST</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>52,349</u>	<u>52,349</u>
<u>4</u>	<u>V</u>	<u>31 AMORTIZATION</u>		<u>JAMES J GIARDINA</u>	<u>100.00%</u>	<u>168</u>	<u>168</u>
<u>5</u>	<u>V</u>	<u>19 HOME OFFICE/MGMT FEES</u>	<u>66,000</u>	<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>		<u>(66,000)</u>
<u>6</u>	<u>V</u>	<u>34 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>6,402</u>	<u>6,402</u>
<u>7</u>	<u>V</u>	<u>35 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>2,920</u>	<u>2,920</u>
<u>8</u>	<u>V</u>	<u>10 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>6,573</u>	<u>6,573</u>
<u>9</u>	<u>V</u>	<u>17 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>16,865</u>	<u>16,865</u>
<u>10</u>	<u>V</u>	<u>21 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>34,213</u>	<u>34,213</u>
<u>11</u>	<u>V</u>	<u>22 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>8,590</u>	<u>8,590</u>
<u>12</u>	<u>V</u>	<u>19 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>1,875</u>	<u>1,875</u>
<u>13</u>	<u>V</u>	<u>24 HOME OFFICE/MGMT FEES</u>		<u>COMMUNITY CARE CENTERS, INC.</u>	<u>100.00%</u>	<u>3,906</u>	<u>3,906</u>
<u>14</u>	<u>Total</u>		<u>\$ 260,700</u>			<u>\$ 161,465</u>	<u>\$ * (99,235)</u>

* 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%	\$ 239	\$ 239	15	
16	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	157	157	16	
17	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	48	48	17	
18	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	31	31	18	
19	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	100.00%	120	120	19	
20	V	22 WORKERS COMP INSURANCE	33,224	RISA	25.00%	33,224		20	
21	V	26 LIABILITY INSURANCE	26,553	RISA	25.00%	26,553		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		\$ 59,777			\$ 60,372	\$ *	595	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: 10/01/07 Ending: 9/30/08

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	\$ 12,346	17.7	1
2	BETTY HUGHES	SECRETARY				1	2.00		1,033	17.7	2
3	LORRAINE BOYET	SECRETARY				1	2.00		1,304	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,683		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: 10/01/07

Ending: 9/30/08

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	WEST COUNTY CARE CENTER			\$	\$	5,576,345	\$ 282,290	1
2		ST GENEVIEVE CARE CTR					2,367,632	83,909	2
3		CCC OF LEMAY					2,479,484	96,051	3
4		SALEM CARE CENTER					1,746,988	63,666	4
5		MONMOUTH NH					2,126,548	81,939	5
6		MAR-KA NH					2,712,435	120,923	6
7		CCC OF SENECA					2,734,042	100,226	7
8		MT VERNON PLACE CARE					2,601,692	98,578	8
9		COUNTRY VIEW NH					2,220,110	88,721	9
10		MERAMEC NH					2,805,995	108,740	10
11		SEVILLE CARE CENTER					3,145,601	112,149	11
12		SALEM RES CARE					556,627	19,492	12
13		CARL JUNCTION RES CARE					612,517	21,449	13
14		MT VERNON RES CARE					462,316	16,190	14
15		SENECA HOME PLACE					447,852	15,684	15
16		HUDSON HOUSE					517,592	18,125	16
17		MAPLE GROVE LODGE					3,049,347	117,264	17
18		CCC OF AURORA					4,817,184	170,686	18
19		BARRY COMMUNITY CARE					2,824,348	99,903	19
20		LICKING RESIDENTIAL CTR					445,895	15,614	20
21		CCC OF GAINESVILLE					2,514,144	94,279	21
22		AL OF SILVER CREEK					654,275	22,912	22
23		CCC OF LICKING					2,483,065	97,672	23
24		COMMUNITY IN HOME					913,173	32,238	24
25	TOTALS				\$	\$		\$ 1,978,700	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		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	DUE TO SHAREHOLDERS	X									16,275						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 16,275						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 16,275						

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.)

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

0027979 Report Period Beginning: **10/01/07**

Ending: **9/30/08**

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	30,060	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	38,317	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,257	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	37,057	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	35,438	8	
	2004	38,805	9	
	2005	39,332	10	
	2006	39,850	11	
	2007	38,317	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>38,207.32</u>	\$ <u>38,207.32</u>
2. _____	<u>SUNSET VIEW ADDN</u>	\$ _____	\$ _____
3. <u>09-393-001-000</u>	<u>63.43' N END W PT BLOCK 3</u>	\$ <u>109.46</u>	\$ <u>109.46</u>
4. _____	<u>WEST PARD ADDN</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>38,316.78</u>	\$ <u>38,316.78</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

10/01/07 Ending:

9/30/08

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:

10/01/07

Ending:

9/30/08

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	\$ 482,845	4
5	19			1990	653,401		3-30	20,104	20,104	405,455	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 \$8,651 - desk audit adj off)		2002			8				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 (orig \$10,829-desk audit adj to \$953)		2003	953		10			953	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		Life of Lease			1,153	31
32		NEW CARPETING & SUBFLOOR (orig \$20,011; adj to \$17,453)		2005	17,453		Life of Lease			17,453	32
33		SMOKE DAMPER		2005	1,440		Life of Lease			1,440	33
34		WANDERGUARD SYSTEM		2005	8,249		Life of Lease			8,249	34
35		MAIN ROOF (\$25,000 desk audit adj off)		2005			Life of Lease				35
36		GRAVEL FOR SIDE PARKING LOT (\$1,102 desk audit adj off)		2006			Life of Lease				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:

10/01/07

Ending:

9/30/08

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	COURTYARD ROOF (\$1,178 desk audit adj off)	2007	\$	\$ 404	Life of Lease	\$	\$ (404)	\$	37
38	AMANA HEAT PUMP	2007	1,815	768	Life of Lease	768		768	38
39	BOILER VALVE & PUMP	2007	1,508	603	Life of Lease	603		603	39
40	ELECTRICAL WORK	2008	2,020	703	Life of Lease	703		703	40
41	2 ADDL WG MONITORS	2008	2,563	301	Life of Lease	301		301	41
42	SIDEWALKS	2008	1,400	88	Life of Lease	88		88	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)		\$ 1,174,351	\$ 2,867		\$ 30,067	\$ 27,200	\$ 986,945	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: 10/01/07 Ending: 9/30/08

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	\$ 197,393	\$ 15,155	\$ 15,155	\$		\$ 141,617	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 197,393	\$ 15,155	\$ 15,155	\$		\$ 141,617	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)		\$ 1,403,424	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 18,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 45,222	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 27,200	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,140,562	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.

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/01/07

Ending: 9/30/08

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	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ \$831

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	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	\$	663	\$ 42,342	\$ 157	663	\$ 42,499	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		73	4,478		73	4,478	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		810	53,180		810	53,180	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	1,546	\$ 100,000	\$ 157	1,546	\$ 100,157	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: 10/01/07

Ending:

9/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/08

(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	\$ 10,878	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,440)	321,069		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,843		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(135,884)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 207,906	\$	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	145,368		15
16	Equipment, at Historical Cost	209,393		16
17	Accumulated Depreciation (book methods)	(287,007)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,254	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 277,160	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 74,082	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,057		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,775		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,800		32
33	Accrued Interest Payable	52,000		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DUE TO RELATED PARTIES	591,071		36
37	PATIENT FUNDS/DUE TO MCR	4,822		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 829,607	\$	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)	\$ 829,607	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (552,447)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 277,160	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (367,957)	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (367,958)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(184,489)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (184,489)	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)	\$ (552,447)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/01/07

Ending: 9/30/08

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	\$ 8,886,625	1
2	Discounts and Allowances for all Levels	(7,213,224)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,673,401	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,205	6
7	Oxygen	82,886	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 323,091	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	7,947	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)	\$ 7,947	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,070	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,070	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	1,500	28
28a	MISCELLANEOUS INCOME	50	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,550	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,008,059	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	513,062	31
32	Health Care	969,713	32
33	General Administration	410,496	33
B. Capital Expense			
34	Ownership	266,885	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	32,392	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,192,548	40
41	Income before Income Taxes (line 30 minus line 40)**	(184,489)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (184,489)	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 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: **10/01/07**

Ending:

9/30/08

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	1,946	2,166	\$ 47,125	\$ 21.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,705	4,273	75,418	17.65	3
4	Licensed Practical Nurses	13,575	14,737	214,996	14.59	4
5	CNAs & Orderlies	41,286	44,221	385,990	8.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,924	2,135	19,139	8.96	9
10	Activity Assistants	1,079	1,167	10,025	8.59	10
11	Social Service Workers	2,817	3,082	33,744	10.95	11
12	Dietician					12
13	Food Service Supervisor	1,872	2,088	20,630	9.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,576	3,858	34,078	8.83	15
16	Dishwashers	7,227	7,782	60,966	7.83	16
17	Maintenance Workers	1,800	2,084	21,947	10.53	17
18	Housekeepers	9,523	10,588	87,470	8.26	18
19	Laundry	5,200	5,607	45,897	8.19	19
20	Administrator	1,962	2,109	63,400	30.06	20
21	Assistant Administrator					21
22	Other Administrative	2,078	2,298	25,639	11.16	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	279	315	2,675	8.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,849	108,510	\$ 1,149,139 *	\$ 10.59	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	95	5,400	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant		226	10.3	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	26	1,788	11.3	44
45	Social Service Consultant	26	1,788	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	333	\$ 14,517		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

Facility Name & ID Number MONMOUTH NURSING HOME

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		\$ 47,563	Workers' Compensation Insurance	\$ 33,224	IDPH License Fee	\$		
KATHYRN KOPSACK	ADMINISTRATOR		15,837	Unemployment Compensation Insurance		Advertising: Employee Recruitment	292		
				FICA Taxes	98,607	Health Care Worker Background Check	900		
				Employee Health Insurance	28,388	(Indicate # of checks performed <u>90</u>)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	2,802		
				OTHER EMPLOYEE BENEFITS	3,952	TAXES & LICENSES	1,475		
				401K CONTRIBUTIONS	897	ADVERTISING OTHER	6,146		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,400	HOME OFFICE ALLOCATION	8,590	HOME OFFICE ALLOCATION	48		
B. Administrative - Other						Less: Public Relations Expense	()		
Description			Amount			Non-allowable advertising	(5,468)		
			\$			Yellow page advertising	(678)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 173,658	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,517		
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		\$ 66,000			\$	Out-of-State Travel	\$	
ELVIDGE KELLEY	LEGAL FEES		165				In-State Travel	4,501	
BKD, LLP	ACCOUNTING FEES		14,775				MEALS	55	
							Seminar Expense		
							HOME OFFICE ALLOCATION	3,906	
							Entertainment Expense	(55)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,940	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 8,407	

* Attach copy of IMRF notifications

**See instructions.

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. \$ 2,003 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. \$ 32,392
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. Schedule attached
- 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? 9%
- 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.