

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	21,535	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	21,535	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	8,104	6,898	1,992	16,994	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,104	6,898	1,992	16,994	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.91%

D. How many bed-hold days during this year were paid by the Department? NONE (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) NONE

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 1,456

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/14 Fiscal Year: 9/30/14

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

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	167,922	12,274	3,772	183,968		183,968		183,968		1
2	Food Purchase		112,524		112,524		112,524	(9,189)	103,335		2
3	Housekeeping	106,385	16,546		122,931		122,931	131	123,062		3
4	Laundry	56,251	13,483		69,734		69,734		69,734		4
5	Heat and Other Utilities			68,642	68,642		68,642		68,642		5
6	Maintenance	31,689	17,112	28,808	77,609		77,609	67	77,676		6
7	Other (specify):*										7
8	TOTAL General Services	362,247	171,939	101,222	635,408		635,408	(8,991)	626,417		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	954,117	58,018	6,681	1,018,816		1,018,816	3,590	1,022,406		10
10a	Therapy			180,311	180,311		180,311		180,311		10a
11	Activities	42,664	920	6,312	49,896		49,896		49,896		11
12	Social Services	32,115		1,650	33,765		33,765		33,765		12
13	CNA Training										13
14	Program Transportation			2,316	2,316		2,316	(760)	1,556		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,028,896	58,938	203,870	1,291,704		1,291,704	2,830	1,294,534		16
	C. General Administration										
17	Administrative	70,237			70,237		70,237	9,690	79,927		17
18	Directors Fees										18
19	Professional Services			123,902	123,902		123,902	(114,656)	9,246		19
20	Dues, Fees, Subscriptions & Promotions			10,748	10,748		10,748	(4,907)	5,841		20
21	Clerical & General Office Expenses	32,195	7,166	34,473	73,834		73,834	39,077	112,911		21
22	Employee Benefits & Payroll Taxes			200,640	200,640		200,640	7,518	208,158		22
23	Inservice Training & Education			1,575	1,575		1,575		1,575		23
24	Travel and Seminar			2,208	2,208		2,208	1,257	3,465		24
25	Other Admin. Staff Transportation							211	211		25
26	Insurance-Prop.Liab.Malpractice			27,440	27,440		27,440	39	27,479		26
27	Other (specify):*										27
28	TOTAL General Administration	102,432	7,166	400,986	510,584		510,584	(61,771)	448,813		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,493,575	238,043	706,078	2,437,696		2,437,696	(67,932)	2,369,764		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.

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			77,531	77,531		77,531	20,104	97,635			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			3,569	3,569		3,569	12,240	15,809			32
33	Real Estate Taxes			39,250	39,250		39,250		39,250			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(188,933)	5,767			34
35	Rent-Equipment & Vehicles			4,944	4,944		4,944	2,457	7,401			35
36	Other (specify):*											36
37	TOTAL Ownership			319,994	319,994		319,994	(153,964)	166,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,345		57,345		57,345		57,345			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,618	126,618		126,618		126,618			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		57,345	126,618	183,963		183,963		183,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,493,575	295,388	1,152,690	2,941,653		2,941,653	(221,896)	2,719,757			45

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/1/13

Ending: 9/30/14

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	(8,945)	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	(347)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(244)	2		13
14	Non-Care Related Interest				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	(7,028)	21		18
19	Entertainment				19
20	Contributions	(200)	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	(4,107)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(653)	20		28
29	Other-Attach Schedule	(2,089)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,613)		\$	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)	(198,283)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,283)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (221,896)		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					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/1/13

Ending: 9/30/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NONALLOWABLE IHCA DUES	\$ (1,044)	21	1
2	MISCELLANEOUS INCOME	(285)	21	2
3	RESIDENT TRANSPORTATION	(760)	14	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		(2,089)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/13

Ending:

9/30/14

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	(9,189)	0	0	0	0	0	0	0	0	0	0	(9,189)	2
3	Housekeeping	0	0	131	0	0	0	0	0	0	0	0	131	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	67	0	0	0	0	0	0	0	0	67	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,189)	0	198	0	(8,991)	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	0	3,590	0	0	0	0	0	0	0	0	3,590	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	(760)	0	0	0	0	0	0	0	0	0	0	(760)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(760)	0	3,590	0	2,830	16							
	C. General Administration													
17	Administrative	0	0	9,690	0	0	0	0	0	0	0	0	9,690	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(114,656)	0	0	0	0	0	0	0	0	(114,656)	19
20	Fees, Subscriptions & Promotions	(4,760)	0	(147)	0	0	0	0	0	0	0	0	(4,907)	20
21	Clerical & General Office Expenses	(8,557)	0	47,634	0	0	0	0	0	0	0	0	39,077	21
22	Employee Benefits & Payroll Taxes	0	0	7,518	0	0	0	0	0	0	0	0	7,518	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,257	0	0	0	0	0	0	0	0	1,257	24
25	Other Admin. Staff Transportation	0	0	211	0	0	0	0	0	0	0	0	211	25
26	Insurance-Prop.Liab.Malpractice	0	0	39	0	0	0	0	0	0	0	0	39	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,317)	0	(48,454)	0	(61,771)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,266)	0	(44,666)	0	(67,932)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending:

9/30/14

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	20,104	0	0	0	0	0	0	0	0	0	20,104	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(347)	12,587	0	0	0	0	0	0	0	0	0	12,240	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(194,700)	5,767	0	0	0	0	0	0	0	0	(188,933)	34
35	Rent-Equipment & Vehicles	0	0	2,457	0	0	0	0	0	0	0	0	2,457	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(347)	(161,841)	8,224	0	(153,964)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(23,613)	(161,841)	(36,442)	0	0	0	0	0	0	0	0	(221,896)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	BALLWIN, MO	HOME OFFICE
		BARRY COMMUNITY CARE CENTER	BARRY	CARE CENTERS		
				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	32 INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	12,587	12,587	2
3	V	30 DEPRECIATION		JAMES J. GIARDINA	100.00%	20,104	20,104	3
4	V	31 AMORTIZATION		JAMES J. GIARDINA	100.00%	168	168	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V	26 LIABILITY INS	22,125	RISA	25.00%	22,125		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 216,825			\$ 54,984	\$ * (161,841)	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	19 HOME OFFICE	\$ 115,200	COMMUNITY CARE CENTERS, INC.	COMMON	\$	\$ (115,200)
16	V	34 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,767	5,767
17	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,457	2,457
18	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	3,590	3,590
19	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,690	9,690
20	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	47,634	47,634
21	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,518	7,518
22	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	544	544
23	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,257	1,257
24	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	211	211
25	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	67	67
26	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	(147)	(147)
27	V	26 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	39	39
28	V	3 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 115,200			\$ 78,758	\$ * (36,442)

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

Facility Name & ID Number

MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending:

9/30/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/13 Ending: 9/30/14

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	NONE	2	4.00	SALARY	\$ 7,634	17.7	1
2	JESSICA CRANE	SECRETARY			NONE	2	5.00	SALARY	2,056	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	\$ 9,690		13

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

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending:

9/30/14

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

Name of Related Organization COMMUNITY CARE CENTERS, INC.
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	WEST COUNTY CARE CENTER				\$	\$	5,531,350	\$ 154,842	1
2	ST GENEVIEVE CARE CTR						2,756,639	81,278	2
3	CCC OF LEMAY						2,724,094	79,334	3
4	SALEM CARE CENTER						1,893,145	51,446	4
5	MONMOUTH NH						2,826,453	78,758	5
6	MAR-KA NH						2,921,273	113,902	6
7	CCC OF SENECA						3,304,709	102,240	7
8	MT VERNON PLACE CARE						2,975,734	102,810	8
9	COUNTRY VIEW NH						2,391,841	75,486	9
10	MERAMEC NH						2,849,145	126,161	10
11	SEVILLE CARE CENTER						3,583,655	107,949	11
12	SALEM RES CARE						635,057	26,832	12
13	CARL JUNCTION RES CARE						710,916	28,829	13
14	MT VERNON RES CARE						452,196	22,018	14
15	SENECA HOME PLACE						498,180	23,227	15
16	HUDSON HOUSE						595,650	25,791	16
17	MAPLE GROVE LODGE						3,104,434	98,055	17
18	CCC OF AURORA						4,344,828	119,275	18
19	BARRY COMMUNITY CARE						3,242,953	98,435	19
20	LICKING RESIDENTIAL CTR						400,529	20,653	20
21	CCC OF GAINESVILLE						3,386,138	94,581	21
22	AL OF SILVER CREEK						797,826	31,114	22
23	MARK TWAIN MANOR						6,279,125	174,003	23
24	CCC OF LICKING						2,623,355	71,781	24
25	TOTALS				\$	\$		\$ 1,908,800	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending: 9/30/14

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

Name of Related Organization COMMUNITY CARE CENTERS, INC.
 Street Address 312 SOLLEY DRIVE - REAR
 City / State / Zip Code BALLWIN, MO 63201
 Phone Number (636) 394-3000
 Fax Number (636) 394-7713

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

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	COMMUNITY IN HOME				\$	\$	1,013,495	26,679	1
2									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	TOTALS				\$	\$		26,679	25

Facility Name & ID Number

MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending:

9/30/14

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	CFS CORP FLEET SERV		X	BUS	\$988.74	3/10/11	\$ 51,341	\$ 24,734	2/10/17	12.1750	\$ 3,569						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related				\$988.74		\$ 51,341	\$ 24,734			\$ 3,569						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 51,341	\$ 24,734			\$ 3,569						

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.)

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 2013 report.		\$	29,700		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.)		\$	39,250		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	9,550		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	29,700		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.		\$	39,250		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>40,213</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>38,855</u>	9																
	2011	<u>39,468</u>	10																
	2012	<u>39,434</u>	11																
	2013	<u>39,250</u>	12																

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.

2013 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 #: (636) 394-7713

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-532-008-00</u>	<u>LOTS 6, 7, 9, 10 & 11 BLOCK 2</u>	\$ <u>39,250.40</u>	\$ <u>39,250.40</u>
2. _____	<u>SUNSET VIEW ADDN</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>39,250.40</u></u>	\$ <u><u>39,250.40</u></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 and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning:

10/1/13 Ending:

9/30/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number **MONMOUTH NURSING HOME**# **0027979**

Report Period Beginning:

10/1/13

Ending:

9/30/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1983	1959	\$ 415,462	\$	10-20	\$	\$	\$	4
5				1990	653,401	20,104	3-30	20,104			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		2003	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:

10/1/13

Ending:

9/30/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	\$	\$	Life of Lease	\$	\$	\$	37
38	AMANA HEAT PUMP (\$1,815 removed 2012 desk audit)	2007			Life of Lease				38
39	BOILER VALVE & PUMP (\$1,508 removed 2012 desk audit)	2007			Life of Lease				39
40	ELECTRICAL WORK (\$2,020 removed 2012 desk audit)	2008			Life of Lease				40
41	2 ADDL WG MONITORS (\$2,563 moved to Equip-2012 desk audi	2008			Life of Lease				41
42	SIDEWALKS (\$1,400 removed 2012 desk audit)	2008			Life of Lease				42
43	DMP ALARM EQUIPMENT (\$1,628 removed 2012 desk audit)	2009			Life of Lease				43
44	100 GAL WATER HEATER	2009	3,776		Life of Lease			3,776	44
45	RAILINGS	2009	2,684		Life of Lease			2,684	45
46	REPLACE OUTSIDE DOORS DR & KT	2010	4,478		Life of Lease			4,478	46
47	MIXING VALVE ON MAIN SHOWER RM \$1,334 removed 2012	2011			Life of Lease				47
48	REPLACE COLD WATER PIPE BSMT (\$1,102 removed 2012 de	2011			Life of Lease				48
49	UPGRADE ALARM SYSTEM (\$1,238 removed 2012 desk audit)	2011			Life of Lease				49
50	NEW ROOF	2011	9,290		Life of Lease			9,290	50
51	OFFICE FURNACE & A/C	2011	5,800		Life of Lease			5,800	51
52	RESTORING WASH HOUSE (\$2,485 removed 2012 desk audit)	2011			Life of Lease				52
53	3 WATER HEATERS (\$13,203 adj to \$12,645 at 2012 desk audit)	2012	12,645		Life of Lease			12,645	53
54	STORM WATER DRAIN	2012	4,500		Life of Lease			4,500	54
55	2 4-TON CONDENSERS	2012	5,400		Life of Lease			5,400	55
56	REPLACE FIRE ALARM SYSTEM/WANDERGUARD	2013	10,775	3,694	Life of Lease	3,694		6,157	56
57	NURSES STATION REMODEL - CONTRACT-OFFICE SPECIA	2013	5,511	1,945	Life of Lease	1,945		3,080	57
58	INSTALL NEW WINDOW	2013	1,594	598	Life of Lease	598		847	58
59	REPLACE PIPES IN ATTIC	2013	5,988	2,318	Life of Lease	2,318		3,091	59
60	NEW ROOF	2013	5,250	2,172	Life of Lease	2,172		2,534	60
61	SPRINKLER HEADS	2013	25,456	10,534	Life of Lease	10,534		12,289	61
62	CARPET HALLWAYS 1,2,3 & BLUE ROOM - CONTRACT-SCC	2013	36,551	11,246	Life of Lease	11,246		22,492	62
63	TILE HALL BATHROOMS - CONTRACT-SCOTT HARRISON	2013	3,726	1,146	Life of Lease	1,146		2,292	63
64	PAINT ENTIRE FACILITY - CONTRACT -LEWIS W SMITH/L	2013	8,543	2,629	Life of Lease	2,629		5,258	64
65	CUBICLE CURTAINS ALL ROOMS/DRAPERIES - CONTRAC	2013	6,847	2,107	Life of Lease	2,107		4,214	65
66	SPRINKLER SYSTEM PIPES & SPRINKLER WORK	2014	40,139	17,727	Life of Lease	17,727		17,727	66
67	EXTERIOR WORK	2014	3,813	803	Life of Lease	803		803	67
68	VINYL FENCING-150 FT	2014	5,600	933	Life of Lease	933		933	68
69		2014							69
70	TOTAL (lines 4 thru 69)		\$ 1,373,411	\$ 77,956		\$ 77,956	\$	\$ 226,472	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 192,707	\$ 6,456	\$ 6,456	\$		\$ 172,053	71
72	Current Year Purchases	6,990	388	388			388	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 199,697	\$ 6,844	\$ 6,844	\$		\$ 172,441	75

D. Vehicle Costs. (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		2011 CHAMP CHAL BUS	2011	\$ 51,341	\$ 12,835	\$ 12,835	\$	4	\$ 44,923	76
77										77
78										78
79										79
80	TOTALS			\$ 51,341	\$ 12,835	\$ 12,835	\$		\$ 44,923	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)	\$ 1,644,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,635	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,635	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 443,836	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: N/A

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 4,994 Description: Water Softener \$1,602; Storage Unit \$1,512; Mattresses \$297; Medical Equip. \$1,533

(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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	10.a2&3	hrs	\$	1,262	\$ 84,186						1,262	\$ 84,186			1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		198	11,994						198	11,994			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10.a2&3	hrs		1,278	84,131						1,278	84,131			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-02	# of prescripts							50,360					50,360	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): Lab & X-ray	39-02								6,985					6,985	13
14	TOTAL			\$	2,738	\$ 180,311	\$	57,345		2,738	\$	237,656				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: **10/1/13**

Ending:

9/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/14** (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	\$ 27,511	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	482,308		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,033		6
7	Other Prepaid Expenses	151		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	32,063		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 554,066	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	362,077		15
16	Equipment, at Historical Cost	251,038		16
17	Accumulated Depreciation (book methods)	(496,736)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS, CIP	31,684		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 148,063	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 702,129	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 216,552	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,807		28
29	Short-Term Notes Payable	9,365		29
30	Accrued Salaries Payable	92,000		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,944		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Unpaid Leases	238,950		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 596,318	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	15,369		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)	\$ 15,369	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 611,687	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 90,442	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 702,129	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (557,682)	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)	\$ (557,681)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(110,477)	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) ADD'L PAID IN CAPITAL	758,600	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 648,123	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)	\$ 90,442	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,448,728	1
2	Discounts and Allowances for all Levels	(12,284,443)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,164,285	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	521,769	6
7	Oxygen	131,785	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 653,554	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	8,945	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)	\$ 8,945	23
D. Non-Operating Revenue			
24	Contributions	3,000	24
25	Interest and Other Investment Income***	347	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,347	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RES TRANSP/MISC INCOME	1,045	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,045	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,831,176	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	635,408	31
32	Health Care	1,291,704	32
33	General Administration	510,584	33
B. Capital Expense			
34	Ownership	319,994	34
C. Ancillary Expense			
35	Special Cost Centers	57,345	35
36	Provider Participation Fee	126,618	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,941,653	40
41	Income before Income Taxes (line 30 minus line 40)**	(110,477)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (110,477)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 978,194	44
45	Private Pay - Net Inpatient Revenue	1,031,767	45
46	Medicare - Net Inpatient Revenue	615,411	46
47	Other-(specify) <u>HOSPICE</u>	66,331	47
48	Other-(specify) <u>PY C/A; PT A ANC; PT B & BAD DEBTS</u>	(527,418)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,164,285	49

* 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:

10/1/13

Ending:

9/30/14

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	1,838	2,025	\$ 57,096	\$ 28.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,837	4,064	89,103	21.92	3
4	Licensed Practical Nurses	16,076	17,596	282,597	16.06	4
5	CNAs & Orderlies	45,814	49,192	475,908	9.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,854	2,065	26,647	12.90	9
10	Activity Assistants	1,688	1,768	16,017	9.06	10
11	Social Service Workers	1,861	2,126	32,115	15.11	11
12	Dietician					12
13	Food Service Supervisor	1,918	2,130	27,583	12.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,830	7,643	75,877	9.93	15
16	Dishwashers	7,003	7,354	64,462	8.77	16
17	Maintenance Workers	2,055	2,293	31,689	13.82	17
18	Housekeepers	9,814	11,108	106,385	9.58	18
19	Laundry	5,843	6,269	56,251	8.97	19
20	Administrator	1,867	2,080	70,237	33.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,857	2,149	32,195	14.98	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	3,389	3,808	49,413	12.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,544	123,670	\$ 1,493,575 *	\$ 12.08	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	88	\$ 3,772	1.3	35
36	Medical Director	96	6,600	9.3	36
37	Medical Records Consultant	32	2,259	10.3	37
38	Nurse Consultant		215	10.3	38
39	Pharmacist Consultant	72	3,399	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	30	1,650	11.3	44
45	Social Service Consultant	30	1,650	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	\$ 19,545		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
JOYCE JUERGENS	ADMINISTRATOR		\$ 70,237	Workers' Compensation Insurance	\$ 41,295	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		393	
				FICA Taxes	123,246	Health Care Worker Background Check		813	
				Employee Health Insurance	29,035	(Indicate # of checks performed <u>89</u>)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS		3,334	
				OTHER EMPLOYEE BENEFITS	4,911	TAXES & LICENSES		1,448	
				401K CONTRIBUTION	2,153	ADVERTISING-OTHER		4,760	
						NONALLOWABLE IHCA DUES (In 21)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,237			HOME OFFICE ALLOCATION		(147)	
B. Administrative - Other						Less: Public Relations Expense	(
Description			Amount			Non-allowable advertising		(4,107)	
			\$			Yellow page advertising		(653)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services									
Vendor/Payee	Type		Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
COMMUNITY CARE CENTERS	MGT FEE		\$ 115,200	Description	Line #	Amount	Description	Amount	
						\$	Out-of-State Travel	\$	
SCHINDLER LAW FIRM	LEGAL		236						
ROSENBLUM, GOLDENHERSH	LEGAL		16				In-State Travel	2,208	
BKD, LLP	ACCOUNTING		8,450				Seminar Expense		
							HOME OFFICE ALLOCATION	1,257	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 123,902	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 3,465	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/13

Ending: 9/30/14

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? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC \$2,714
- (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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,158 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. \$ 126,618
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? NO
If YES, attach a complete explanation.
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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 51%
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? YES
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? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.