

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning: 10/1/14 Ending: 9/30/15

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	7,411	7,538	2,552	17,501	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,411	7,538	2,552	17,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.27%

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 1,698

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/15 Fiscal Year: 9/30/15

* 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	172,097	13,980	4,286	190,363		190,363		190,363		1
2	Food Purchase		114,569		114,569		114,569	(10,974)	103,595		2
3	Housekeeping	108,361	14,683		123,044		123,044	134	123,178		3
4	Laundry	58,491	9,231		67,722		67,722		67,722		4
5	Heat and Other Utilities			69,822	69,822		69,822		69,822		5
6	Maintenance	36,356	23,422	48,368	108,146		108,146	173	108,319		6
7	Other (specify):*										7
8	TOTAL General Services	375,305	175,885	122,476	673,666		673,666	(10,667)	662,999		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	952,275	51,736	6,766	1,010,777		1,010,777	6,379	1,017,156		10
10a	Therapy			166,500	166,500		166,500		166,500		10a
11	Activities	43,854	805	4,467	49,126		49,126		49,126		11
12	Social Services	32,407		1,375	33,782		33,782		33,782		12
13	CNA Training										13
14	Program Transportation			1,657	1,657		1,657	(525)	1,132		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,028,536	52,541	187,365	1,268,442		1,268,442	5,854	1,274,296		16
	C. General Administration										
17	Administrative	72,984			72,984		72,984	10,006	82,990		17
18	Directors Fees			2,400	2,400		2,400		2,400		18
19	Professional Services			126,626	126,626		126,626	(114,054)	12,572		19
20	Dues, Fees, Subscriptions & Promotions			16,877	16,877		16,877	(5,779)	11,098		20
21	Clerical & General Office Expenses	32,008	9,108	30,703	71,819		71,819	48,261	120,080		21
22	Employee Benefits & Payroll Taxes			220,196	220,196		220,196	7,831	228,027		22
23	Inservice Training & Education			1,272	1,272		1,272		1,272		23
24	Travel and Seminar			2,293	2,293		2,293	2,222	4,515		24
25	Other Admin. Staff Transportation							289	289		25
26	Insurance-Prop.Liab.Malpractice			36,001	36,001		36,001	39	36,040		26
27	Other (specify):*										27
28	TOTAL General Administration	104,992	9,108	436,368	550,468		550,468	(51,185)	499,283		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,508,833	237,534	746,209	2,492,576		2,492,576	(55,998)	2,436,578		29

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

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

Facility Name & ID Number MONMOUTH NURSING HOME

#0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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			108,053	108,053		108,053	15,705	123,758			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			2,500	2,500		2,500	11,328	13,828			32
33	Real Estate Taxes			40,105	40,105		40,105		40,105			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(189,051)	5,649			34
35	Rent-Equipment & Vehicles			4,123	4,123		4,123	2,529	6,652			35
36	Other (specify):*											36
37	TOTAL Ownership			349,481	349,481		349,481	(159,321)	190,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,759		63,759		63,759		63,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,226	128,226		128,226		128,226			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		63,759	128,226	191,985		191,985		191,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,508,833	301,293	1,223,916	3,034,042		3,034,042	(215,319)	2,818,723			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: **10/1/14**

Ending: **9/30/15**

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	(10,702)	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	(216)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	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	(483)	21		18
19	Entertainment				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	(5,369)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(510)	20		28
29	Other-Attach Schedule	(7,130)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,682)		\$	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)	(190,637)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (190,637)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (215,319)		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: 10/1/14

Ending: 9/30/15

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NONALLOWABLE IHCA DUES	\$ (1,313)	21	1
2	MISCELLANEOUS INCOME	(893)	21	2
3	RESIDENT TRANSPORTATION	(525)	14	3
4	DEPRECIATION - CAP COST AUDIT ADJS PG12	(4,399)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(7,130)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	(10,974)	0	0	0	0	0	0	0	0	0	0	(10,974)	2
3	Housekeeping	0	0	134	0	0	0	0	0	0	0	0	134	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	173	0	0	0	0	0	0	0	0	173	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,974)	0	307	0	(10,667)	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	6,379	0	0	0	0	0	0	0	0	6,379	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	(525)	0	0	0	0	0	0	0	0	0	0	(525)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(525)	0	6,379	0	5,854	16							
	C. General Administration													
17	Administrative	0	0	10,006	0	0	0	0	0	0	0	0	10,006	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(114,054)	0	0	0	0	0	0	0	0	(114,054)	19
20	Fees, Subscriptions & Promotions	(5,879)	0	100	0	0	0	0	0	0	0	0	(5,779)	20
21	Clerical & General Office Expenses	(2,689)	0	50,950	0	0	0	0	0	0	0	0	48,261	21
22	Employee Benefits & Payroll Taxes	0	0	7,831	0	0	0	0	0	0	0	0	7,831	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,222	0	0	0	0	0	0	0	0	2,222	24
25	Other Admin. Staff Transportation	0	0	289	0	0	0	0	0	0	0	0	289	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	(8,568)	0	(42,617)	0	(51,185)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,067)	0	(35,931)	0	(55,998)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	(4,399)	20,104	0	0	0	0	0	0	0	0	0	15,705	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(216)	11,544	0	0	0	0	0	0	0	0	0	11,328	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)	5,649	0	0	0	0	0	0	0	0	(189,051)	34
35	Rent-Equipment & Vehicles	0	0	2,529	0	0	0	0	0	0	0	0	2,529	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,615)	(162,884)	8,178	0	(159,321)	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)	(24,682)	(162,884)	(27,753)	0	0	0	0	0	0	0	0	(215,319)	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%	11,544	11,544	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	20,650	RISA	25.00%	20,650		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 215,350			\$ 52,466	\$ * (162,884)	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	5,649	5,649
17	V	35 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,529	2,529
18	V	10 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	6,379	6,379
19	V	17 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	10,006	10,006
20	V	21 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	50,950	50,950
21	V	22 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,831	7,831
22	V	19 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,146	1,146
23	V	24 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,222	2,222
24	V	25 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	289	289
25	V	6 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	173	173
26	V	20 HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	100	100
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	134	134
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 115,200			\$ 87,447	\$ * (27,753)

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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		\$			\$	0	\$ *

* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							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		\$			\$	0	\$ *	39

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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		\$			\$	0	\$ *

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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		\$			\$	0	\$ *

* 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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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		\$			\$	0	\$ *

* 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		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							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		\$			\$	0	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							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		\$			\$	0	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							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		\$			\$	0	\$ *

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

Facility Name & ID Number

MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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:

10/1/14

Ending:

9/30/15

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: 10/1/14 Ending: 9/30/15

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	\$ 7,855	17.7	1
2	JESSICA CRANE	SECRETARY			NONE	3	6.00	SALARY	857	17.7	2
3	MARY SCHAPER	SECRETARY			NONE	2	4.00	SALARY	1,294	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,006		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:

10/1/14

Ending:

9/30/15

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				\$	\$	5,372,369	\$ 161,690	1
2	ST GENEVIEVE CARE CTR						2,761,386	81,581	2
3	CCC OF LEMAY						2,835,048	96,608	3
4	SALEM CARE CENTER						2,010,928	59,024	4
5	MONMOUTH NH						2,918,842	87,447	5
6	MAR-KA NH						2,870,136	110,557	6
7	CCC OF SENECA						3,421,590	98,556	7
8	MT VERNON PLACE CARE						2,933,603	92,002	8
9	COUNTRY VIEW NH						2,429,561	107,373	9
10	MERAMEC NH						2,875,470	95,102	10
11	SEVILLE CARE CENTER						3,442,240	108,489	11
12	SALEM RES CARE						626,780	27,720	12
13	CARL JUNCTION RES CARE						713,170	30,078	13
14	MT VERNON RES CARE						471,981	23,499	14
15	SENECA HOME PLACE						531,306	25,113	15
16	HUDSON HOUSE						632,047	27,860	16
17	MAPLE GROVE LODGE						3,265,527	139,553	17
18	CCC OF AURORA						4,395,027	119,928	18
19	BARRY COMMUNITY CARE						3,215,958	97,629	19
20	LICKING RESIDENTIAL CTR						437,484	22,552	20
21	CCC OF GAINESVILLE						3,208,634	87,554	21
22	AL OF SILVER CREEK						805,349	32,590	22
23	MARK TWAIN MANOR						6,256,415	186,853	23
24	CCC OF LICKING						2,551,127	71,689	24
25	TOTALS				\$	\$		\$ 1,991,047	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending: 9/30/15

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
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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	COMMUNITY IN HOME				\$	\$	1,077,834	\$ 29,944	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				\$	\$		\$ 29,944	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending: 9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
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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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

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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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
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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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending: 9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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				\$	\$		\$	25

Facility Name & ID Number

MONMOUTH NURSING HOME

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	\$ 15,370	2/10/17	12.1750	\$ 2,500	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$988.74		\$ 51,341	\$ 15,370			\$ 2,500	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 51,341	\$ 15,370			\$ 2,500	15					

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

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

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

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 2014 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.)		\$	39,655	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	9,955	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,150	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.		\$	40,105	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>38,855</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 2014 \$</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 2014 \$	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 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>39,468</u>	9																
	2012	<u>39,434</u>	10																
	2013	<u>39,250</u>	11																
	2014	<u>39,655</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.

2014 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 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-532-008-00</u>	<u>LOTS 6, 7, 9, 10 & 11 BLOCK 2</u>	\$ <u>39,655.00</u>	\$ <u>39,655.00</u>
2. _____	<u>SUNSET VIEW ADDN</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>39,655.00</u></u>	\$ <u><u>39,655.00</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONMOUTH NURSING HOME COUNTY WARREN

FACILITY IDPH LICENSE NUMBER 0027979

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning:

10/1/14 Ending:

9/30/15

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).

NONE

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	<u>FACILITY</u>	<u>50,094</u>	<u>1983</u>	<u>\$ 12,180</u>	<u>1</u>
2			<u>1990</u>	<u>7,500</u>	<u>2</u>
3	TOTALS	50,094		\$ 19,680	3

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

Report Period Beginning:

10/1/14

Ending:

9/30/15**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	59		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(\$4,570 removed per 2015 desk audit)		1991							9
10		ROOF REPAIRS(\$3,181 removed per 2015 desk audit)		1992							10
11		CARPETING(\$4,074 removed per 2015 desk audit)		1992							11
12		CARPETING(\$4,411 removed per 2015 desk audit)		1993							12
13		ROOF REPAIRS(\$1,380 removed per 2015 desk audit)		1996							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(\$2,712 removed per 2015 desk audit)		2001							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(\$2,022 removed per 2015 desk audit)		2003							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		CARPET/SUBFLOOR (removed 17,453 per 2015 audit) (orig \$20,011; ad		2005			Life of Lease				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:

10/1/14

Ending:

9/30/15**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	<u>COURTYARD ROOF (\$1,178 desk audit adj off)</u>	2007	\$	\$	Life of Lease	\$	\$	\$	37
38	<u>AMANA HEAT PUMP (\$1,815 removed 2012 desk audit)</u>	2007			Life of Lease				38
39	<u>BOILER VALVE & PUMP (\$1,508 removed 2012 desk audit)</u>	2007			Life of Lease				39
40	<u>ELECTRICAL WORK (\$2,020 removed 2012 desk audit)</u>	2008			Life of Lease				40
41	<u>2 ADDL WG MONITORS (\$2,563 moved to Equip-2012 desk audi</u>	2008			Life of Lease				41
42	<u>SIDEWALKS (\$1,400 removed 2012 desk audit)</u>	2008			Life of Lease				42
43	<u>DMP ALARM EQUIPMENT (\$1,628 removed 2012 desk audit)</u>	2009			Life of Lease				43
44	<u>100 GAL WATER HEATER(\$3,776 removed per 2015 desk audit)</u>	2009							44
45	<u>RAILINGS</u>	2009	2,684		Life of Lease			2,684	45
46	<u>REPLACE OUTSIDE DOORS DR & KT</u>	2010	4,478		Life of Lease			4,478	46
47	<u>MIXING VALVE ON MAIN SHOWER RM \$1,334 removed 2012</u>	2011			Life of Lease				47
48	<u>REPLACE COLD WATER PIPE BSMT (\$1,102 removed 2012 de</u>	2011			Life of Lease				48
49	<u>UPGRADE ALARM SYSTEM (\$1,238 removed 2012 desk audit)</u>	2011			Life of Lease				49
50	<u>NEW ROOF</u>	2011	9,290		Life of Lease			9,290	50
51	<u>OFFICE FURNACE & A/C</u>	2011	5,800		Life of Lease			5,800	51
52	<u>RESTORING WASH HOUSE (\$2,485 removed 2012 desk audit)</u>	2011			Life of Lease				52
53	<u>3 WATER HEATERS (\$13,203 adj to \$12,645 at 2012 desk audit)</u>	2012	12,645		Life of Lease			12,645	53
54	<u>STORM WATER DRAIN</u>	2012	4,500		Life of Lease			4,500	54
55	<u>2 4-TON CONDENSERS</u>	2012	5,400		Life of Lease			5,400	55
56	<u>REPLACE FIRE ALARM SYSTEM(removed \$1,553 2015 desk au</u>	2013	9,222	3,694	Life of Lease	3,065	(629)	9,222	56
57	<u>NRS STATION REMODEL-CONTR (\$5,511 removed 2015 desk a</u>	2013		450			(450)		57
58	<u>INSTALL NEW WINDOW(\$1,594 removed per 2015 Desk Audit)</u>	2013		598			(598)		58
59	<u>REPLACE PIPES IN ATTIC</u>	2013	5,988	2,318	Life of Lease	2,318		5,409	59
60	<u>NEW ROOF</u>	2013	5,250	2,173	Life of Lease	2,173		4,707	60
61	<u>SPRINKLER HEADS</u>	2013	25,456	10,534	Life of Lease	10,534		22,823	61
62	<u>Carpet Halls 1,2,3 & Blue RM-Contract-Scott Harrison(changed v</u>	2011	36,551	11,246	Life of Lease	11,246		33,738	62
63	<u>TILE HALL BATHROOMS - CONTRACT-SCOTT HARRISON</u>	2013	3,726	1,146	Life of Lease	1,146		3,438	63
64	<u>PAINT ENTIRE FACILITY - CONTRACT -LEWIS W SMITH/L</u>	2013	8,543	2,629	Life of Lease	2,629		7,887	64
65	<u>CUBICLE CURTAINS ALL ROOMS/DRAPERIES - CONTRAC</u>	2013	6,847	2,107	Life of Lease	2,107		6,321	65
66	<u>SPRINKLER SYSTEM PIPES & SPRINKLER WORK</u>	2014	40,139	17,929	Life of Lease	17,929		35,656	66
67	<u>EXTERIOR WORK</u>	2014	3,813	2,408	Life of Lease	2,408		3,211	67
68	<u>VINYL FENCING-150 FT</u>	2014	5,600	3,734	Life of Lease	3,734		4,667	68
69	<u>2 FURNACES & 2 A/C CONDENSING UNITS</u>	2014	10,685	8,548	Life of Lease	8,548		8,548	69
70	<u>TOTAL (lines 4 thru 69)</u>		\$ 1,331,859	\$ 89,618		\$ 87,941	\$ (1,677)	\$ 246,803	70

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

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	
1	Totals from Page 12A, Carried Forward		\$ 1,331,859	\$ 89,618		\$ 87,941	\$ (1,677)	\$ 246,803	1
2	100-GAL A O SMITH WATER HEATER	2014	3,187	2,452	Life of Lease	2,452		2,452	2
3	2.5-TON A/C FOR KITCHEN(\$1,595 removed per 2015 Desk Aud	2014		1,227	Life of Lease		(1,227)		3
4	RPZ ON FIRE MAIN	2015	4,979	3,485	Life of Lease	3,485		3,485	4
5	WANDERGUARD PLUS 4 SIGNALLING DEVICES(\$1,503 remc	2015		939	Life of Lease		(939)		5
6	OLYMPIAN NATURAL GAS GENERATOR	2015	22,550	14,094	Life of Lease	14,094		14,094	6
7	50-GALLON WATER HEATER FOR STORAGE ROOM(\$973 re	2015		556	Life of Lease		(556)		7
8	GAS LINE	2015	2,410	1,377	Life of Lease	1,377		1,377	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	TOTAL (lines 1 thru 33)		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	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
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	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
31								31
32								32
33								33
34		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12E, Carried Forward		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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	TOTAL (lines 1 thru 33)		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	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
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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	TOTAL (lines 1 thru 33)	\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12G, Carried Forward		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	1
2									2
3									3
4									4
5									5
6									6
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

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

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

0027979

Report Period Beginning:

10/1/14

Ending:

9/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1	Totals from Page 12H, Carried Forward		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	1
2									2
3									3
4									4
5									5
6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,364,985	\$ 113,748		\$ 109,349	\$ (4,399)	\$ 268,211	34

**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	\$ 197,371	\$ 7,603	\$ 7,603	\$		\$ 175,849	71
72	Current Year Purchases	7,001	388	388			388	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 204,372	\$ 7,991	\$ 7,991	\$		\$ 176,237	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	\$ 6,418	\$ 6,418	\$	4	\$ 51,341	76
77										77
78										78
79										79
80	TOTALS			\$ 51,341	\$ 6,418	\$ 6,418	\$		\$ 51,341	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)	\$ 1,640,378	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 128,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,758	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,399)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 495,789	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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 4,123 Description: Water Softener \$1,699; Storage Unit \$1,512; Mattresses \$850; Medical Equip. \$29; Cement Mixer \$33

(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.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/14 Ending: 9/30/15
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10.a2&3	hrs	\$	1,106	\$ 67,145	\$	1,106	\$ 67,145	1	
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		405	21,617		405	21,617	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10.a2&3	hrs		1,289	77,738		1,289	77,738	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 prescrpts				55,736		55,736	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					8,023		8,023	13	
14	TOTAL			\$	2,800	\$ 166,500	\$ 63,759	2,800	\$ 230,259	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: **10/1/14**

Ending:

9/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **9/30/15** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 68,803	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	587,492		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,073		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from MCR/Due to/From CC	47,334		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 714,702	\$	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	376,868		15
16	Equipment, at Historical Cost	251,478		16
17	Accumulated Depreciation (book methods)	(565,136)		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):	3,800		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 67,010	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 781,712	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 241,450	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,571		29
30	Accrued Salaries Payable	90,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,802		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,150		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Unpaid Leases	256,650		36
37	Resrv est ins/Patient Liab	104,617		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 739,947	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,799		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)	\$ 4,799	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 744,746	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 36,966	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 781,712	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 90,442	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)	\$ 90,443	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,477)	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (53,477)	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)	\$ 36,966	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	\$ 14,885,274	1
2	Discounts and Allowances for all Levels	(12,587,640)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,297,634	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	526,592	6
7	Oxygen	144,003	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 670,595	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	10,702	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)	\$ 10,702	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	216	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 216	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RES TRANSP/MISC INCOME	1,418	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,418	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,980,565	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	673,666	31
32	Health Care	1,268,442	32
33	General Administration	550,468	33
B. Capital Expense			
34	Ownership	349,481	34
C. Ancillary Expense			
35	Special Cost Centers	63,759	35
36	Provider Participation Fee	128,226	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,034,042	40
41	Income before Income Taxes (line 30 minus line 40)**	(53,477)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (53,477)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 896,273	44
45	Private Pay - Net Inpatient Revenue	1,164,946	45
46	Medicare - Net Inpatient Revenue	735,160	46
47	Other-(specify) HOSPICE	105,175	47
48	Other-(specify) PY C/A; PT A ANC; PT B & BAD DEBTS	(603,920)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,297,634	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:

10/1/14

Ending:

9/30/15

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	1,719	1,839	\$ 48,056	\$ 26.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,744	4,011	90,561	22.58	3
4	Licensed Practical Nurses	15,825	17,321	282,417	16.30	4
5	CNAs & Orderlies	45,515	48,954	476,536	9.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	2,096	27,596	13.17	9
10	Activity Assistants	1,684	1,762	16,257	9.23	10
11	Social Service Workers	1,837	2,101	32,407	15.42	11
12	Dietician					12
13	Food Service Supervisor	1,889	2,129	28,068	13.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,819	8,663	85,580	9.88	15
16	Dishwashers	6,341	6,647	58,449	8.79	16
17	Maintenance Workers	2,512	2,752	36,357	13.21	17
18	Housekeepers	9,810	11,066	108,361	9.79	18
19	Laundry	5,821	6,381	58,491	9.17	19
20	Administrator	1,844	2,080	72,984	35.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,858	2,090	32,008	15.31	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	3,676	4,037	54,705	13.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	113,702	123,929	\$ 1,508,833 *	\$ 12.17	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	100	\$ 4,286	1.3	35
36	Medical Director	96	6,600	9.3	36
37	Medical Records Consultant	32	2,357	10.3	37
38	Nurse Consultant		300	10.3	38
39	Pharmacist Consultant	72	3,321	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	25	2,750	11.3	44
45	Social Service Consultant	25	2,750	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	\$ 22,364		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			\$ 72,984	Workers' Compensation Insurance	\$ 41,865	IDPH License Fee	\$	
					Unemployment Compensation Insurance		Advertising: Employee Recruitment		954
					FICA Taxes	129,776	Health Care Worker Background Check		
					Employee Health Insurance	43,561	(Indicate # of checks performed <u>90</u>)		886
					Employee Meals		Patient Background Checks		
					Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS		3,681
					OTHER EMPLOYEE BENEFITS	3,380	TAXES & LICENSES		5,477
					401K CONTRIBUTION	1,614	ADVERTISING-OTHER		5,879
							NONALLOWABLE IHCA DUES (In 21)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 72,984			HOME OFFICE ALLOCATION		100
B. Administrative - Other							Less: Public Relations Expense	(
Description				Amount			Non-allowable advertising		(5,369)
				\$			Yellow page advertising		(510)
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	\$ 503	
SCHINDLER LAW FIRM	LEGAL		130						
ROSENBLUM, GOLDENHERSH	LEGAL		36				In-State Travel	1,790	
BKD, LLP	ACCOUNTING		11,260				Seminar Expense		
							HOME OFFICE ALLOCATION	2,222	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 126,626	TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$	4,515

* 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:

10/1/14

Ending:

9/30/15

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 \$3,469
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,209 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. N/A
- (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. \$ 128,226
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.
- 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? 42%
- 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: N/A
- (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.