FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0027979

Facility Name: MONMOUTH NURSING HOME

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

County: WARREN

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[X] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) JAMES J. GIARDINA
(Title) PRESIDENT

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL E. BUEKER, CPA — PARTNER
(Firm Name & Address) BKD, LLP — P. O. BOX 1190, SPRINGFIELD, MO 65801
(Telephone) (417) 865-8701 Fax # 417-865-0682

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

STATE OF ILLINOIS

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,194	6,142	2,545	16,881	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,194	6,142	2,545	16,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.39%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 11/11/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 59 and days of care provided 1,515

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 9/30/10 Fiscal Year: 9/30/10

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	154,910	9,119	4,115	168,144		168,144		168,144			1
2	Food Purchase		96,021		96,021		96,021	(9,263)	86,758			2
3	Housekeeping	108,892	16,467		125,359		125,359	136	125,495			3
4	Laundry	53,183	10,917		64,100		64,100		64,100			4
5	Heat and Other Utilities			65,667	65,667		65,667		65,667			5
6	Maintenance	24,276	17,331	26,187	67,794		67,794	48	67,842			6
7	Other (specify):*											7
8	**TOTAL General Services**	341,261	149,855	95,969	587,085		587,085	(9,079)	578,006			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	864,339	98,020	2,596	964,955		964,955	4,517	969,472			10
10a	Therapy		242	193,596	193,838		193,838		193,838			10a
11	Activities	35,805	958	3,911	40,674		40,674		40,674			11
12	Social Services	31,894		1,238	33,132		33,132		33,132			12
13	CNA Training											13
14	Program Transportation			27	27		27	(73)	(46)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	932,038	99,220	206,768	1,238,026		1,238,026	4,444	1,242,470			16
	C. General Administration											
17	Administrative	48,389			48,389		48,389	6,543	54,932			17
18	Directors Fees											18
19	Professional Services			83,385	83,385		83,385	(63,879)	19,506			19
20	Dues, Fees, Subscriptions & Promotions			15,187	15,187		15,187	(5,363)	9,824			20
21	Clerical & General Office Expenses	31,517	7,905	18,011	57,433		57,433	46,987	104,420			21
22	Employee Benefits & Payroll Taxes			203,190	203,190		203,190	9,252	212,442			22
23	Inservice Training & Education			5,694	5,694		5,694		5,694			23
24	Travel and Seminar			2,297	2,297		2,297	3,943	6,240			24
25	Other Admin. Staff Transportation							210	210			25
26	Insurance-Prop.Liab.Malpractice			28,538	28,538		28,538	36	28,574			26
27	Other (specify):*											27
28	**TOTAL General Administration**	79,906	7,905	356,302	444,113		444,113	(2,271)	441,842			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,353,205	256,980	659,039	2,269,224		2,269,224	(6,906)	2,262,318			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: 10/1/09 Ending: 9/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,888	17,888		17,888	20,003	37,891			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			19,663	19,663		19,663	96	19,759			32
33	Real Estate Taxes			41,113	41,113		41,113		41,113			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(187,615)	7,085			34
35	Rent-Equipment & Vehicles			3,105	3,105		3,105	1,745	4,850			35
36	Other (specify):*											36
37	**TOTAL Ownership**			276,469	276,469		276,469	(165,603)	110,866			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,303	32,303		32,303		32,303			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			32,303	32,303		32,303		32,303			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,353,205	256,980	967,811	2,577,996		2,577,996	(172,509)	2,405,487			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: 10/1/09 Ending: 9/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,061)	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	(3,022)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	2		13
14	Non-Care Related Interest	(19,663)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(66)	21		18
19	Entertainment	(144)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,129)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(271)	20		28
29	Other-Attach Schedule	(1,422)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,980)		$	30

BHF USE ONLY

48		49		50		51		52	

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 Amount	2 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)	(134,529)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (134,529)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (172,509)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/1/09

Ending: 9/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ 0	21	1
2	MISCELLANEOUS INCOME	(164)	21	2
3	TRAVEL CHGED TO RESIDENT	(73)	14	3
4	ADJ TO S/L DEPR	(101)	30	4
5	NONALLOWABLE IHCA DUES	(1,029)	20	5
6	RESIDENT SALES	(55)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,422)		49

STATE OF ILLINOIS Summary A

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,263)	0	0	0	0	0	0	0	0	0	0	(9,263)	2
3	Housekeeping	0	0	136	0	0	0	0	0	0	0	0	136	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	48	0	0	0	0	0	0	0	0	48	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,263)	0	184	0	0	0	0	0	0	0	0	(9,079)	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	(55)	4,572	0	0	0	0	0	0	0	0	0	4,517	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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(128)	4,572	0	0	0	0	0	0	0	0	0	4,444	16
	C. General Administration													
17	Administrative	0	6,543	0	0	0	0	0	0	0	0	0	6,543	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(63,879)	0	0	0	0	0	0	0	0	0	(63,879)	19
20	Fees, Subscriptions & Promotions	(5,429)	0	66	0	0	0	0	0	0	0	0	(5,363)	20
21	Clerical & General Office Expenses	(230)	47,217	0	0	0	0	0	0	0	0	0	46,987	21
22	Employee Benefits & Payroll Taxes	0	9,252	0	0	0	0	0	0	0	0	0	9,252	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(144)	4,087	0	0	0	0	0	0	0	0	0	3,943	24
25	Other Admin. Staff Transportation	0	0	210	0	0	0	0	0	0	0	0	210	25
26	Insurance-Prop.Liab.Malpractice	0	0	36	0	0	0	0	0	0	0	0	36	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,803)	3,220	312	0	0	0	0	0	0	0	0	(2,271)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,194)	7,792	496	0	0	0	0	0	0	0	0	(6,906)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(101)	20,104	0	0	0	0	0	0	0	0	0	20,003	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(22,685)	22,781	0	0	0	0	0	0	0	0	0	96	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(187,615)	0	0	0	0	0	0	0	0	0	(187,615)	34
35	Rent-Equipment & Vehicles	0	1,745	0	0	0	0	0	0	0	0	0	1,745	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,786)	(142,817)	0	0	0	0	0	0	0	0	0	(165,603)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,980)	(135,025)	496	0	0	0	0	0	0	0	0	(172,509)	45

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	BUILDING RENT	$ 194,700	JAMES J. GIARDINA	100.00%	$	$ (194,700)	1
2	V	32	INTEREST EXPENSE		JAMES J. GIARDINA	100.00%	22,781	22,781	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	19	HOME OFFICE	66,000	COMMUNITY CARE CENTERS, INC.	COMMON		(66,000)	5
6	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	7,085	7,085	6
7	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,745	1,745	7
8	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	4,572	4,572	8
9	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	6,543	6,543	9
10	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	47,217	47,217	10
11	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,252	9,252	11
12	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,121	2,121	12
13	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	4,087	4,087	13
14	Total			$ 260,700			$ 125,675	$ * (135,025)	14

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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. [X] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	HOME OFFICE/MGMT FEES	$	COMMUNITY CARE CENTERS, INC.	COMMON	$ 210	$ 210	15
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	48	48	16
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	66	66	17
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	36	36	18
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	136	136	19
20	V	22	WORKERS COMP INS	47,377	RISA	25.00%	47,377		20
21	V	26	LIABILITY INS	23,600	RISA	25.00%	23,600		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			$ 70,977			$ 71,473	$ * 496	39

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	JAMES J GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	2	4.00	SALARY	$ 5,072	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,471	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	$ 6,543		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: 10/1/09 Ending: 9/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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				$	$	5,678,126	$ 276,770	1
2		ST GENEVIEVE CARE CTR						2,689,168	84,968	2
3		CCC OF LEMAY						2,500,368	87,413	3
4		SALEM CARE CENTER						1,977,805	63,059	4
5		MONMOUTH NH						2,511,996	83,118	5
6		MAR-KA NH						2,783,231	110,115	6
7		CCC OF SENECA						3,020,591	111,698	7
8		MT VERNON PLACE CARE						2,617,962	92,474	8
9		COUNTRY VIEW NH						2,278,766	77,007	9
10		MERAMEC NH						3,007,762	104,114	10
11		SEVILLE CARE CENTER						3,409,016	108,235	11
12		SALEM RES CARE						565,722	27,565	12
13		CARL JUNCTION RES CARE						665,490	30,637	13
14		MT VERNON RES CARE						460,102	24,313	14
15		SENECA HOME PLACE						379,647	21,836	15
16		HUDSON HOUSE						486,419	25,124	16
17		MAPLE GROVE LODGE						3,018,130	101,922	17
18		CCC OF AURORA						4,381,526	135,650	18
19		BARRY COMMUNITY CARE						3,025,157	97,482	19
20		LICKING RESIDENTIAL CTR						409,553	28,849	20
21		CCC OF GAINESVILLE						2,981,165	96,128	21
22		AL OF SILVER CREEK						827,976	35,643	22
23		CCC OF LICKING						2,336,486	76,274	23
24		COMMUNITY IN HOME						986,510	31,090	24
25	TOTALS					$	$		$ 1,931,484	25

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DUE TO SHAREHOLDER	X									19,663	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 19,663	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 19,663	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.)

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 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.)	$	40,213	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,513	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,600	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.	$	41,113	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2005	39,332	8
2006	39,850	9
2007	38,317	10
2008	39,167	11
2009	40,213	12

FOR BHF USE ONLY

Line	Description		Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2009	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONMOUTH NURSING HOME COUNTY WARREN

FACILITY IDPH LICENSE NUMBER 0027979

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE (636) 394-3000 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	09-532-008-00	LOTS 6, 7, 9, 10 & 11 BLOCK 2	$ 40,092.06	$ 40,092.06
2.		SUNSET VIEW ADDN	$	$
3.	09-393-001-00	63.43' N END W PT BLOCK 3	$ 120.90	$ 120.90
4.		WEST PARD ADDN	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,212.96	$ 40,212.96

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 10/1/09 Ending: 9/30/10

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 [X] (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 [X] (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 [X] 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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	35		1983	1959	$ 415,462	$	10-20	$	$	$ 484,720	4
5	19			1990	653,401	20,104	3-30	20,104		465,767	5
6											6
7											7
8											8
	Improvement Type**										
9	DRAPERY AND CUBICAL			1991	4,570		10			4,570	9
10	ROOF REPARIS			1992	3,181		10			3,181	10
11	CARPETING			1992	4,074		5			4,074	11
12	CARPETING			1993	4,411		5			4,411	12
13	ROOF REPAIRS			1996	1,380		10			1,380	13
14	ALARM			1997	7,078		15			7,078	14
15	NURSE CALL SYSTEM			2000	7,347		10			7,347	15
16	FIRE ALARM SYSTEM			2001	2,587		10			2,587	16
17	HOT WATER HEATER			2001	2,712		10			2,712	17
18	DOOR			2002	5,112		20			5,112	18
19	BLACKTOP DRIVEWAYS $8,651 - desk audit adj off)			2002			8				19
20	MIXING VALVE ON WATER			2002	987		20			987	20
21											21
22	FIXTURES			2002	3,231		10			3,231	22
23	ROOF OVER KITCHEN			2002	9,892		10			9,892	23
24	WHIRLPOOL TUB (orig $10,829-desk audit adj to $953)			2003	953		10			953	24
25	GUTTERS			2003	1,000		10			1,000	25
26	RACKS FOR ROOMS			2003	1,526		10			1,526	26
27	WATER HEATER			2003	2,022		10			2,022	27
28	SIDEWALKS			2004	1,350		15			1,350	28
29	EAST SIDEWALKS			2004	1,200		15			1,200	29
30	HOPPER			2004	3,274		20			3,274	30
31	4 VINYL WINDOWS			2004	1,153		Life of Lease			1,153	31
32	NEW CARPETING & SUBFLOOR (orig $20,011; adj to $17,453)			2005	17,453		Life of Lease			17,453	32
33	SMOKE DAMPER			2005	1,440		Life of Lease			1,440	33
34	WANDERGUARD SYSTEM			2005	8,249		Life of Lease			8,249	34
35	MAIN ROOF ($25,000 desk audit adj off)			2005			Life of Lease				35
36	GRAVEL FOR SIDE PARKING LOT ($1,102 desk audit adj off)			2006			Life of Lease				36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	COURTYARD ROOF ($1,178 desk audit adj off)	2007	$	$ 101	Life of Lease	$	$ (101)	$	37
38	AMANA HEAT PUMP	2007	1,815	209	Life of Lease	209		1,815	38
39	BOILER VALVE & PUMP	2007	1,508	181	Life of Lease	181		1,508	39
40	ELECTRICAL WORK	2008	2,020	263	Life of Lease	263		2,020	40
41	2 ADDL WG MONITORS	2008	2,563	452	Life of Lease	452		2,563	41
42	SIDEWALKS	2008	1,400	263	Life of Lease	263		1,400	42
43	DMP ALARM EQUIPMENT	2009	1,628	488	Life of Lease	488		1,628	43
44	100 GAL WATER HEATER	2009	3,776	1,259	Life of Lease	1,259		3,776	44
45	RAILINGS	2009	2,684	2,684	Life of Lease	2,684		2,684	45
46	REPLACE OUTSIDE DOORS DR & KT	2010	4,478	160	Life of Lease	160		160	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,186,917	$ 26,164		$ 26,063	$ (101)	$ 1,064,223	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 197,704	$ 11,828	$ 11,828	$		$ 162,207	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 197,704	$ 11,828	$ 11,828	$		$ 162,207	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,416,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,891	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (101)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,238,430	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

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

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 3,105 Description: Water softener $1,756; Medical equip $1,343; Misc $6
    (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: 10/1/09 Ending: 9/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	1,357	$ 93,902	$	1,357	$ 93,902	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		118	7,304		118	7,304	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,322	92,390		1,322	92,390	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	2,797	$ 193,596	$	2,797	$ 193,596	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.

STATE OF ILLINOIS

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/10 (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	$ 10,394	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 14,440)	243,913		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,898		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM R/P	232,062		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 498,267	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	157,933		15
16	Equipment, at Historical Cost	209,704		16
17	Accumulated Depreciation (book methods)	(323,192)		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	3,800		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 49,745	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 548,012	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,533	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,098		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,682		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,219		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,600		32
33	Accrued Interest Payable	94,612		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	773,150		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,066,894	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,066,894	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (518,882)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 548,012	$	48

*(See instructions.)

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (566,310)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (566,310)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,428	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)**	$ 47,428	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)**	$ (518,882)	24 *

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,131,928	1
2	Discounts and Allowances for all Levels	(8,123,854)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,008,074	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,969	6
7	Oxygen	151,006	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 604,975	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	9,061	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)**	$ 9,061	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,022	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,022	26
	E. Other Revenue (specify):** **		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	RESIDENT SALES,RES TRAVEL, MISC	292	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 292	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,625,424	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	587,085	31
32	Health Care	1,238,026	32
33	General Administration	444,113	33
	B. Capital Expense		
34	Ownership	276,469	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,303	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,577,996	40
41	**Income before Income Taxes (line 30 minus line 40)****	47,428	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 47,428	43

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

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

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

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	1,992	2,080	$ 55,607	$ 26.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,674	4,064	78,007	19.19	3
4	Licensed Practical Nurses	16,947	18,288	276,823	15.14	4
5	CNAs & Orderlies	45,784	48,803	453,902	9.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,799	2,111	24,839	11.77	9
10	Activity Assistants	1,227	1,325	10,966	8.28	10
11	Social Service Workers	2,243	2,569	31,894	12.41	11
12	Dietician					12
13	Food Service Supervisor	1,865	2,077	22,902	11.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,774	7,323	65,331	8.92	15
16	Dishwashers	7,473	7,961	66,677	8.38	16
17	Maintenance Workers	1,886	2,134	24,276	11.38	17
18	Housekeepers	11,470	12,618	108,892	8.63	18
19	Laundry	5,705	6,209	53,183	8.57	19
20	Administrator	1,555	1,703	48,389	28.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,330	2,586	31,517	12.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,724	121,851	$ 1,353,205 *	$ 11.11	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,115	1.3	35
36	Medical Director	96	5,400	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant		358	10.3	38
39	Pharmacist Consultant	90	2,238	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	20	1,238	11.3	44
45	Social Service Consultant	20	1,238	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	322	$ 14,587		49

C. CONTRACT NURSES

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY KOPSACK	ADMINISTRATOR		$ 38,945
TAMMY GUILE	ADMINISTRATOR		9,444
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,389

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE CENTERS, INC.	MGMT FEES	$ 66,000
ROSENBLUM,GOLDENHER	LEGAL	75
ELVIDGE KELLEY	LEGAL	165
BKD, LLP	ACCOUNTING	17,145
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 83,385

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,377
Unemployment Compensation Insurance	
FICA Taxes	112,202
Employee Health Insurance	37,850
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	4,892
401K CONTRIBUTION	869
HOME OFFICE ALLOCATION	9,252
TOTAL (agree to Schedule V, line 22, col.8)	$ 212,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	510
Health Care Worker Background Check (Indicate # of checks performed 79)	782
Patient Background Checks	
DUES & SUBSCRIPTIONS	4,901
TAXES & LICENSES	4,594
ADVERTISING - OTHER	4,400
NONALLOWABLE IHCA DUES	(1,029)
HOME OFFICE ALLOCATION	66
Less: Public Relations Expense	( )
Non-allowable advertising	(4,129)
Yellow page advertising	(271)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,153
MEALS	144
Seminar Expense	
HOME OFFICE ALLOCATION	4,087
Entertainment Expense	(144)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,240

**See instructions.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/09 Ending: 9/30/10

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
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	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: 10/1/09 Ending: 9/30/10

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 $3,257**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? ______

(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. $ **4,691** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. ______

(9) Are you presently operating under a sublease agreement? ______ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
______

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **32,303**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation. See attached schedule
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? **1%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **NO**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.