FOR BHF USE

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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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 10/1/12 to 9/30/13 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)

Paid Preparer

(Signed) (Date)
(Print Name and Title) CAMILLE LOCKHART, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,509	7,471	1,910	16,890	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,509	7,471	1,910	16,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.43%

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 1,526

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 9/30/13 Fiscal Year: 9/30/13

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,247	17,060	4,115	193,422		193,422		193,422			1
2	Food Purchase		110,514		110,514		110,514	(9,341)	101,173			2
3	Housekeeping	103,482	19,358		122,840		122,840	131	122,971			3
4	Laundry	55,202	13,853		69,055		69,055		69,055			4
5	Heat and Other Utilities			70,289	70,289		70,289		70,289			5
6	Maintenance	33,291	16,204	28,610	78,105		78,105	603	78,708			6
7	Other (specify):*											7
8	**TOTAL General Services**	364,222	176,989	103,014	644,225		644,225	(8,607)	635,618			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	940,510	51,502	6,238	998,250		998,250	2,002	1,000,252			10
10a	Therapy			193,706	193,706		193,706		193,706			10a
11	Activities	42,810	708	5,784	49,302		49,302		49,302			11
12	Social Services	31,207	1,375		32,582		32,582		32,582			12
13	CNA Training											13
14	Program Transportation			2,591	2,591		2,591	(1,300)	1,291			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,014,527	53,585	214,919	1,283,031		1,283,031	702	1,283,733			16
	C. General Administration											
17	Administrative	70,566			70,566		70,566	9,542	80,108			17
18	Directors Fees											18
19	Professional Services			77,101	77,101		77,101	(64,624)	12,477			19
20	Dues, Fees, Subscriptions & Promotions			17,232	17,232		17,232	(7,950)	9,282			20
21	Clerical & General Office Expenses	49,544	7,475	28,634	85,653		85,653	51,518	137,171			21
22	Employee Benefits & Payroll Taxes			203,889	203,889		203,889	6,111	210,000			22
23	Inservice Training & Education			3,077	3,077		3,077		3,077			23
24	Travel and Seminar			5,719	5,719		5,719	1,178	6,897			24
25	Other Admin. Staff Transportation							159	159			25
26	Insurance-Prop.Liab.Malpractice			31,381	31,381		31,381	39	31,420			26
27	Other (specify):*											27
28	**TOTAL General Administration**	120,110	7,475	367,033	494,618		494,618	(4,027)	490,591			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,498,859	238,049	684,966	2,421,874		2,421,874	(11,932)	2,409,942			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: 10/1/12 Ending: 9/30/13

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			55,248	55,248		55,248	20,052	75,300			30
31	Amortization of Pre-Op. & Org.							168	168			31
32	Interest			24,178	24,178		24,178	(23,160)	1,018			32
33	Real Estate Taxes			39,434	39,434		39,434		39,434			33
34	Rent-Facility & Grounds			194,700	194,700		194,700	(189,249)	5,451			34
35	Rent-Equipment & Vehicles			3,308	3,308		3,308	2,239	5,547			35
36	Other (specify):*											36
37	TOTAL Ownership			316,868	316,868		316,868	(189,950)	126,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,177		64,177		64,177		64,177			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,030	168,030		168,030		168,030			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		64,177	168,030	232,207		232,207		232,207			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,498,859	302,226	1,169,864	2,970,949		2,970,949	(201,882)	2,769,067			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: 10/1/12 Ending: 9/30/13

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	$	21	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,087)	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	(52)	30		9
10	Interest and Other Investment Income	(17,289)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(254)	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		21		18
19	Entertainment				19
20	Contributions		21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,468)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(572)	20		28
29	Other-Attach Schedule	(2,967)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,352)		$	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)	(144,530)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (144,530)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,882)		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		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

MONMOUTH NURSING HOME

ID# 0027979

Report Period Beginning: 10/1/12

Ending: 9/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	$ (1,252)	21	1
2	MISCELLANEOUS INCOME	(415)	21	2
3	RESIDENT TRANSPORTATION	(1,300)	14	3
4	COMMISSION ON COLLECTIONS		21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,967)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 **Report Period Beginning:** 10/1/12 **Ending:** 9/30/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,341)	0	0	0	0	0	0	0	0	0	0	(9,341)	2
3	Housekeeping	0	0	131	0	0	0	0	0	0	0	0	131	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	603	0	0	0	0	0	0	0	0	603	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,341)	0	734	0	0	0	0	0	0	0	0	(8,607)	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	2,002	0	0	0	0	0	0	0	0	2,002	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	(1,300)	0	0	0	0	0	0	0	0	0	0	(1,300)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,300)	0	2,002	0	0	0	0	0	0	0	0	702	16
	C. General Administration													
17	Administrative	0	0	9,542	0	0	0	0	0	0	0	0	9,542	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(64,624)	0	0	0	0	0	0	0	0	(64,624)	19
20	Fees, Subscriptions & Promotions	(8,040)	0	90	0	0	0	0	0	0	0	0	(7,950)	20
21	Clerical & General Office Expenses	(1,667)	0	53,185	0	0	0	0	0	0	0	0	51,518	21
22	Employee Benefits & Payroll Taxes	0	0	6,111	0	0	0	0	0	0	0	0	6,111	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,178	0	0	0	0	0	0	0	0	1,178	24
25	Other Admin. Staff Transportation	0	0	159	0	0	0	0	0	0	0	0	159	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**	(9,707)	0	5,680	0	0	0	0	0	0	0	0	(4,027)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,348)	0	8,416	0	0	0	0	0	0	0	0	(11,932)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 **Report Period Beginning:** 10/1/12 **Ending:** 9/30/13

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	(52)	20,104	0	0	0	0	0	0	0	0	0	20,052	30
31	Amortization of Pre-Op. & Org.	0	168	0	0	0	0	0	0	0	0	0	168	31
32	Interest	(36,952)	13,792	0	0	0	0	0	0	0	0	0	(23,160)	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)	5,451	0	0	0	0	0	0	0	0	(189,249)	34
35	Rent-Equipment & Vehicles	0	0	2,239	0	0	0	0	0	0	0	0	2,239	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(37,004)	(160,636)	7,690	0	0	0	0	0	0	0	0	(189,950)	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)	(57,352)	(160,636)	16,106	0	0	0	0	0	0	0	0	(201,882)	45

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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. [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%	13,792	13,792	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	25,813	RISA	25.00%	25,813		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 220,513			$ 59,877	$ * (160,636)	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: 10/1/12 Ending: 9/30/13

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 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)	
15	V	19	HOME OFFICE	$ 66,000	COMMUNITY CARE CENTERS, INC.	COMMON	$	$ (66,000)	15
16	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	5,451	5,451	16
17	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,239	2,239	17
18	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,002	2,002	18
19	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	9,542	9,542	19
20	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	53,185	53,185	20
21	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	6,111	6,111	21
22	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,376	1,376	22
23	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,178	1,178	23
24	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	159	159	24
25	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	603	603	25
26	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	90	90	26
27	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	39	39	27
28	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	131	131	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			$ 66,000			$ 82,106	$ * 16,106	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: 10/1/12 Ending: 9/30/13

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: 10/1/12 Ending: 9/30/13

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	JAMES J. GIARDINA	PRESIDENT	GEN DIRECTOR	100.00	NONE	2	4.00	SALARY	$ 7,630	17.7	1
2	LORRAINE BOYET	SECRETARY			NONE	2	5.00	SALARY	1,314	17.7	2
3	JESSICA CRANE	SECRETARY			NONE	2	5.00	SALARY	598	17.7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,542		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: 10/1/12 Ending: 9/30/13

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 [X] NO [ ]

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

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

	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				$	$	5,784,828	$ 194,691	1
2		ST GENEVIEVE CARE CTR						2,721,730	80,621	2
3		CCC OF LEMAY						2,758,746	85,741	3
4		SALEM CARE CENTER						2,018,561	61,294	4
5		MONMOUTH NH						2,904,949	82,106	5
6		MAR-KA NH						3,030,494	124,996	6
7		CCC OF SENECA						3,302,483	93,020	7
8		MT VERNON PLACE CARE						3,283,148	109,554	8
9		COUNTRY VIEW NH						2,549,564	87,057	9
10		MERAMEC NH						2,855,753	86,653	10
11		SEVILLE CARE CENTER						3,501,582	106,739	11
12		SALEM RES CARE						618,784	27,861	12
13		CARL JUNCTION RES CARE						727,464	30,844	13
14		MT VERNON RES CARE						492,776	24,399	14
15		SENECA HOME PLACE						470,064	23,778	15
16		HUDSON HOUSE						617,735	27,833	16
17		MAPLE GROVE LODGE						3,409,999	107,160	17
18		CCC OF AURORA						4,488,628	130,294	18
19		BARRY COMMUNITY CARE						3,166,164	123,429	19
20		LICKING RESIDENTIAL CTR						402,502	21,924	20
21		CCC OF GAINESVILLE						3,519,536	104,876	21
22		AL OF SILVER CREEK						788,475	33,711	22
23		MARK TWAIN MANOR						6,342,220	178,821	23
24		CCC OF LICKING						2,775,510	78,552	24
25	TOTALS					$	$		$ 2,025,954	25

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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 [X] NO [ ]

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

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

	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				$	$	1,052,552	$ 28,896	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					$	$		$ 28,896	25

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CFS CORP FLEET SERV		X	BUS	$988.74	3/10/11	$ 51,341	$ 33,031	2/10/17	12.1750	$ 4,515	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				$988.74		$ 51,341	$ 33,031			$ 24,178	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	$ 33,031			$ 24,178	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: 10/1/12 Ending: 9/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)		$ 39,434	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,734	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 29,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 39,434	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	39,167	8
	2009	40,213	9
	2010	38,855	10
	2011	39,468	11
	2012	39,434	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-532-008-00	LOTS 6, 7, 9, 10 & 11 BLOCK 2	$ 39,434.22	$ 39,434.22
2.		SUNSET VIEW ADDN	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,434.22	$ 39,434.22

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 10/1/12 Ending: 9/30/13

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 Use	2 Square Feet	3 Year Acquired	4 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: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1983	1959	$ 415,462	$	10-20	$	$	$	4
5				1990	653,401	20,104	3-30	20,104			5
6											6
7											7
8											8
	Improvement Type**										
9	DRAPERY AND CUBICAL			1991	4,570		10			4,570	9
10	ROOF 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			2003	3,274		20			3,274	30
31	4 VINYL WINDOWS			2004	1,153		Life of Lease			1,153	31
32	NEW CARPETING & SUBFLOOR (orig $20,011; adj to $17,453)			2005	17,453		Life of Lease			17,453	32
33	SMOKE DAMPER			2005	1,440		Life of Lease			1,440	33
34	WANDERGUARD SYSTEM			2005	8,249		Life of Lease			8,249	34
35	MAIN ROOF ($25,000 desk audit adj off)			2005			Life of Lease				35
36	GRAVEL FOR SIDE PARKING LOT ($1,102 desk audit adj off)			2006			Life of Lease				36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COURTYARD ROOF ($1,178 desk audit adj off)	2007	$	$	Life of Lease	$	$	$	37
38	AMANA HEAT PUMP ($1,815 removed 2012 desk audit)	2007			Life of Lease				38
39	BOILER VALVE & PUMP ($1,508 removed 2012 desk audit)	2007			Life of Lease				39
40	ELECTRICAL WORK ($2,020 removed 2012 desk audit)	2008			Life of Lease				40
41	2 ADDL WG MONITORS ($2,563 moved to Equip-2012 desk audi	2008			Life of Lease				41
42	SIDEWALKS ($1,400 removed 2012 desk audit)	2008			Life of Lease				42
43	DMP ALARM EQUIPMENT ($1,628 removed 2012 desk audit)	2009			Life of Lease				43
44	100 GAL WATER HEATER	2009	3,776		Life of Lease			3,776	44
45	RAILINGS	2009	2,684		Life of Lease			2,684	45
46	REPLACE OUTSIDE DOORS DR & KT	2010	4,478	480	Life of Lease	480		4,478	46
47	MIXING VALVE ON MAIN SHOWER RM $1,334 removed 2012	2011		167	Life of Lease		(167)		47
48	REPLACE COLD WATER PIPE BSMT ($1,102 removed 2012 de	2011		176	Life of Lease		(176)		48
49	UPGRADE ALARM SYSTEM ($1,238 removed 2012 desk audit)	2011		186	Life of Lease		(186)		49
50	NEW ROOF	2011	9,290	1,639	Life of Lease	1,639		9,290	50
51	OFFICE FURNACE & A/C	2011	5,800	1,087	Life of Lease	1,087		5,800	51
52	RESTORING WASH HOUSE ($2,485 removed 2012 desk audit)	2011		437	Life of Lease		(437)		52
53	3 WATER HEATERS ($13,203 adj to $12,645 at 2012 desk audit)	2012	12,645	3,301	Life of Lease	4,215	914	12,645	53
54	STORM WATER DRAIN	2012	4,500	1,929	Life of Lease	1,929		4,500	54
55	2 4-TON CONDENSERS	2012	5,400	2,700	Life of Lease	2,700		5,400	55
56	REPLACE FIRE ALARM SYSTEM/WANDERGUARD	2013	10,775	2,463	Life of Lease	2,463		2,463	56
57	NURSES STATION REMODEL - CONTRACT-OFFICE SPECIA	2013	5,511	1,135	Life of Lease	1,135		1,135	57
58	INSTALL NEW WINDOW	2013	1,594	249	Life of Lease	249		249	58
59	REPLACE PIPES IN ATTIC	2013	5,988	773	Life of Lease	773		773	59
60	NEW ROOF	2013	5,250	362	Life of Lease	362		362	60
61	SPRINKLER HEADS	2013	25,456	1,756	Life of Lease	1,756		1,756	61
62	CARPET HALLWAYS 1,2,3 & BLUE ROOM - CONTRACT-SC	2013	36,551	11,246	Life of Lease	11,246		11,246	62
63	TILE HALL BATHROOMS - CONTRACT-SCOTT HARRISON	2013	3,726	1,146	Life of Lease	1,146		1,146	63
64	PAINT ENTIRE FACILITY - CONTRACT -LEWIS W SMITH/L	2013	8,543	2,629	Life of Lease	2,629		2,629	64
65	CUBICLE CURTAINS ALL ROOMS/DRAPERIES - CONTRAC	2013	6,847	2,107	Life of Lease	2,107		2,107	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,323,859	$ 56,072		$ 56,020	$ (52)	$ 168,621	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: 10/1/12 Ending: 9/30/13

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	$ 191,404	$ 6,336	$ 6,336	$		$ 165,488	71
72	Current Year Purchases	1,303	109	109			109	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 192,707	$ 6,445	$ 6,445	$		$ 165,597	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2011 CHAMP CHAL BUS	2011	$ 51,341	$ 12,835	$ 12,835	$	4	$ 32,088	76
77										77
78										78
79										79
80	TOTALS			$ 51,341	$ 12,835	$ 12,835	$		$ 32,088	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)	$ 1,587,587	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,352	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,300	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (52)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 366,306	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: 10/1/12 Ending: 9/30/13

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

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 3,308 Description: Water Softener $1,765; Storage Unit $1,458; Medical Equip. $85
    (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: 10/1/12 Ending: 9/30/13

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.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	$	1,361	$ 90,658	$	1,361	$ 90,658	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		317	20,822		317	20,822	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		1,336	82,226		1,336	82,226	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				52,104		52,104	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						12,073		12,073	13
14	TOTAL			$	3,014	$ 193,706	$ 64,177	3,014	$ 257,883	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: 10/1/12 Ending: 9/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/13 (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	$ 66,450	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	519,596		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,620		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from R/P	92,384		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 690,050	$	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	312,525		15
16	Equipment, at Historical Cost	244,048		16
17	Accumulated Depreciation (book methods)	(419,205)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS, CIP	38,680		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 176,048	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 866,098	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 280,198	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,847		28
29	Short-Term Notes Payable	8,296		29
30	Accrued Salaries Payable	90,124		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,030		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,700		32
33	Accrued Interest Payable	153,600		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to R/P	826,250		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,399,045	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,735		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)**	$ 24,735	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,423,780	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (557,682)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 866,098	$	48

***(See instructions.)**

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (339,594)	1
2	Restatements (describe):		2
3	PPA-BAD DEBTS	(12,001)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (351,595)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,087)	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	(100,000)	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)**	$ (206,087)	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)**	$ (557,682)	24 *

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

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,358,417	1
2	Discounts and Allowances for all Levels	(12,257,766)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,100,651	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	575,919	6
7	Oxygen	160,201	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 736,120	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	9,087	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)**	$ 9,087	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,289	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,289	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RES TRANSP/MISC INCOME	1,715	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,715	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,864,862	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	644,225	31
32	Health Care	1,283,031	32
33	General Administration	494,618	33
	B. Capital Expense		
34	Ownership	316,868	34
	C. Ancillary Expense		
35	Special Cost Centers	64,177	35
36	Provider Participation Fee	168,030	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,970,949	40
41	**Income before Income Taxes (line 30 minus line 40)****	(106,087)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (106,087)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 847,973	44
45	Private Pay - Net Inpatient Revenue	1,064,675	45
46	Medicare - Net Inpatient Revenue	214,826	46
47	Other-(specify) Hospice	43,519	47
48	Other-(specify) PY C/A & BAD DEBTS	(70,342)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,100,651	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 DEPRECIATIOI 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: 10/1/12 Ending: 9/30/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,817	2,080	$ 57,509	$ 27.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,872	4,062	85,886	21.14	3
4	Licensed Practical Nurses	18,226	19,744	313,183	15.86	4
5	CNAs & Orderlies	47,151	50,461	479,592	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,823	2,087	26,324	12.61	9
10	Activity Assistants	1,844	1,889	16,486	8.73	10
11	Social Service Workers	1,877	2,125	31,207	14.69	11
12	Dietician					12
13	Food Service Supervisor	1,932	2,184	27,574	12.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,350	8,017	82,363	10.27	15
16	Dishwashers	7,104	7,562	62,310	8.24	16
17	Maintenance Workers	2,282	2,547	33,291	13.07	17
18	Housekeepers	9,795	11,044	103,482	9.37	18
19	Laundry	5,872	6,251	55,202	8.83	19
20	Administrator	1,776	2,080	70,566	33.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,630	4,011	49,544	12.35	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	320	338	4,340	12.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,671	126,482	$ 1,498,859 *	$ 11.85	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,115	1.3	35
36	Medical Director	96	6,600	9.3	36
37	Medical Records Consultant	36	2,602	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	72	3,565	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	1,375	11.3	44
45	Social Service Consultant	25	1,375	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	$ 19,632		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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: 10/1/12 Ending: 9/30/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOYCE JUERGENS	ADMINISTRATOR		$ 70,566
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 70,566

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	MGT FEE	$ 66,000
SCHINDLER LAW FIRM	LEGAL	394
ROSENBLUM, GOLDENHERSH	LEGAL	1,075
ADMIN ACCT	LEGAL-AR COLLECTIONS	102
CCC INC	LEGAL-TERMIN OF AGREE	150
BKD, LLP	ACCOUNTING	9,380
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 77,101

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,544
Unemployment Compensation Insurance	
FICA Taxes	126,943
Employee Health Insurance	28,824
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	4,803
401K CONTRIBUTION	1,775
OSHA EMPLOYEE BENEFITS	
HOME OFFICE ALLOCATION	6,111
TOTAL (agree to Schedule V, line 22, col.8)	$ 210,000

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 128)	1,195
Patient Background Checks	
DUES & SUBSCRIPTIONS	2,603
TAXES & LICENSES	5,394
ADVERTISING-OTHER	8,040
NONALLOWABLE IHCA DUES	
HOME OFFICE ALLOCATION	90
Less: Public Relations Expense	( )
Non-allowable advertising	(7,468)
Yellow page advertising	(572)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,282

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,624
Seminar Expense	
MEALS	95
HOME OFFICE ALLOCATION	1,178
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,897

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MONMOUTH NURSING HOME # 0027979 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	Amount of Expense Amortized Per Year								
					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: 10/1/12 Ending: 9/30/13

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. $ **4,603** 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. $ **168,030**
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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **32%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.