

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0027979</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>MONMOUTH NURSING HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2019</u> to <u>9/30/2020</u> 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.																							
Address: <u>116 SOUTH I STREET</u> <u>MONMOUTH</u> <u>61462</u>																									
Number City Zip Code																									
County: <u>WARREN</u>																									
Telephone Number: <u>(309) 734-3811</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>CHRISTINA GIARDINA</u></td><td></td></tr><tr><td>(Title) <u>PRESIDENT</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>CAMILLE B. LOCKHART, CPA</u> <u>PARTNER</u></td><td></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801</u></td><td></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td><td></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>CHRISTINA GIARDINA</u>		(Title) <u>PRESIDENT</u>		(Signed) _____	(Date) _____	Paid Preparer	(Print Name and Title) <u>CAMILLE B. LOCKHART, CPA</u> <u>PARTNER</u>		(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801</u>		(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>		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					
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	(Type or Print Name) <u>CHRISTINA GIARDINA</u>																								
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	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																								
Date of Initial License for Current Owners: <u>11/11/83</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>CAMILLE B. LOCKHART</u> Telephone Number: <u>417-865-8701</u>																									
Email Address: _____																									

Facility Name & ID Number MONMOUTH NURSING HOME

0027979 Report Period Beginning: 10/1/2019 Ending: 9/30/2020

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	<u>59</u>	Skilled (SNF)	<u>59</u>	<u>21,594</u>	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	<u>59</u>	TOTALS	<u>59</u>	<u>21,594</u>	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	<u>8,601</u>	<u>4,670</u>	<u>3,741</u>	<u>17,012</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,601</u>	<u>4,670</u>	<u>3,741</u>	<u>17,012</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.78%

D. How many bed reserve days during this year were paid by the Department?

NONE (Do not include bed reserve 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

1,288

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

NO

☐

Tax Year: 9/30/20

Fiscal Year: 9/30/20

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

Facility Name & ID Number **MONMOUTH NURSING HOME** # **0027979** Report Period Beginning: **10/1/2019** Ending: **9/30/2020**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	189,525	11,551	9,970	211,046		211,046		211,046			1
2	Food Purchase		115,832		115,832		115,832	(650)	115,182			2
3	Housekeeping	103,856	12,052		115,908		115,908	35	115,943			3
4	Laundry	69,070	4,533		73,603		73,603		73,603			4
5	Heat and Other Utilities			68,533	68,533		68,533		68,533			5
6	Maintenance	37,996	2,813	29,342	70,151		70,151	1,052	71,203			6
7	Other (specify):*							(14,675)	(14,675)			7
8	TOTAL General Services	400,447	146,781	107,845	655,073		655,073	(14,238)	640,835			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,031,033	54,458	5,799	1,091,290		1,091,290	2,356	1,093,646			10
10a	Therapy			145,634	145,634		145,634		145,634			10a
11	Activities	51,100	4,804	445	56,349		56,349		56,349			11
12	Social Services	38,888		275	39,163		39,163		39,163			12
13	CNA Training											13
14	Program Transportation							(2)	(2)			14
15	Other (specify):* Ambulance			(26)	(26)		(26)	(45,532)	(45,558)			15
16	TOTAL Health Care and Programs	1,121,021	59,262	159,327	1,339,610		1,339,610	(43,178)	1,296,432			16
	C. General Administration											
17	Administrative	81,243			81,243		81,243	4,994	86,237			17
18	Directors Fees											18
19	Professional Services			157,360	157,360		157,360	1,763	159,123			19
20	Dues, Fees, Subscriptions & Promotions			21,554	21,554		21,554	(10,019)	11,535			20
21	Clerical & General Office Expenses	59,441	9,829	90,676	159,946		159,946	(6,417)	153,529			21
22	Employee Benefits & Payroll Taxes			159,096	159,096		159,096	1,557	160,653			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,368	3,368		3,368	469	3,837			24
25	Other Admin. Staff Transportation							109	109			25
26	Insurance-Prop.Liab.Malpractice			21,281	21,281		21,281	16	21,297			26
27	Other (specify):*							(1,610)	(1,610)			27
28	TOTAL General Administration	140,684	9,829	453,335	603,848		603,848	(9,138)	594,710			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,662,152	215,872	720,507	2,598,531		2,598,531	(66,554)	2,531,977			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			22,209	22,209		22,209	6,698	28,907			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							41,260	41,260			32
33	Real Estate Taxes			40,800	40,800		40,800		40,800			33
34	Rent-Facility & Grounds			91,980	91,980		91,980	(89,547)	2,433			34
35	Rent-Equipment & Vehicles			1,039	1,039		1,039	230	1,269			35
36	Other (specify):*											36
37	TOTAL Ownership			156,028	156,028		156,028	(41,359)	114,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,359		44,359		44,359		44,359			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,522	126,522		126,522		126,522			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		44,359	126,522	170,881		170,881		170,881			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,662,152	260,231	1,003,057	2,925,440		2,925,440	(107,913)	2,817,527			45

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

	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	(411)	2		4
5	Telephone, TV & Radio in Resident Rooms	(80)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(1,065)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,573)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,041)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,320)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(62,739)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,468)		\$	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)	(12,445)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,445)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (107,913)		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

ID#0027979

Report Period Beginning:10/1/2019

Ending:9/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NONALLOWABLE IHCA DUES	\$ (260)	21	1
2	MISCELLANEOUS INCOME	(660)	21	2
3	RESIDENT TRANSPORTATION	(2)	14	3
4	COVID REIMB - GENERAL	(14,675)	7	4
5	COVID REIMB - HC	(45,532)	15	5
6	COVID REIMB - ADMIN	(1,610)	27	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	(62,739)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/2019

Ending:

9/30/2020

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	(650)	0	0	0	0	0	0	0	0	0	0	(650)	2
3	Housekeeping	0	0	35	0	0	0	0	0	0	0	0	35	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	1,052	0	0	0	0	0	0	0	0	1,052	6
7	Other (specify):*	(14,675)	0	0	0	0	0	0	0	0	0	0	(14,675)	7
8	TOTAL General Services	(15,325)	0	1,087	0	0	0	0	0	0	0	0	(14,238)	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	2,356	0	0	0	0	0	0	0	0	2,356	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	(2)	0	0	0	0	0	0	0	0	0	0	(2)	14
15	Other (specify):*	(45,532)	0	0	0	0	0	0	0	0	0	0	(45,532)	15
16	TOTAL Health Care and Programs	(45,534)	0	2,356	0	0	0	0	0	0	0	0	(43,178)	16
	C. General Administration													
17	Administrative	0	0	4,994	0	0	0	0	0	0	0	0	4,994	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,763	0	0	0	0	0	0	0	0	1,763	19
20	Fees, Subscriptions & Promotions	(10,041)	0	22	0	0	0	0	0	0	0	0	(10,019)	20
21	Clerical & General Office Expenses	(21,893)	0	15,476	0	0	0	0	0	0	0	0	(6,417)	21
22	Employee Benefits & Payroll Taxes	0	0	1,557	0	0	0	0	0	0	0	0	1,557	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	469	0	0	0	0	0	0	0	0	469	24
25	Other Admin. Staff Transportation	0	0	109	0	0	0	0	0	0	0	0	109	25
26	Insurance-Prop.Liab.Malpractice	0	0	16	0	0	0	0	0	0	0	0	16	26
27	Other (specify):*	(1,610)	0	0	0	0	0	0	0	0	0	0	(1,610)	27
28	TOTAL General Administration	(33,544)	0	24,406	0	0	0	0	0	0	0	0	(9,138)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(94,403)	0	27,849	0	0	0	0	0	0	0	0	(66,554)	29

STATE OF ILLINOIS

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/2019

Ending:

Summary B

9/30/2020

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	6,698	0	0	0	0	0	0	0	0	0	6,698	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,065)	42,325	0	0	0	0	0	0	0	0	0	41,260	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(91,980)	2,433	0	0	0	0	0	0	0	0	(89,547)	34
35	Rent-Equipment & Vehicles	0	0	230	0	0	0	0	0	0	0	0	230	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,065)	(42,957)	2,663	0	0	0	0	0	0	0	0	(41,359)	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)	(95,468)	(42,957)	30,512	0	0	0	0	0	0	0	0	(107,913)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

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

1 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	\$ 91,980	JAMES J GIARDINA RVOC LIVING TRUST	100.00%	\$	(91,980)	1
2	V	32	INTEREST EXPENSE		JAMES J GIARDINA RVOC LIVING TRUST	100.00%	42,325	42,325	2
3	V	30	DEPRECIATION		JAMES J GIARDINA RVOC LIVING TRUST	100.00%	6,698	6,698	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V	26	LIABILITY INS	8,510	RISA	25.00%	8,510		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 100,490			\$ 57,533	\$ * (42,957)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference:	
		Item		Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	HOME OFFICE	\$	COMMUNITY CARE CENTERS, INC.	COMMON	\$	\$	15
16	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,433	2,433	16
17	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	230	230	17
18	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	4,994	4,994	18
19	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	2,356	2,356	19
20	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	15,476	15,476	20
21	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,557	1,557	21
22	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,763	1,763	22
23	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	469	469	23
24	V	25	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	109	109	24
25	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	1,052	1,052	25
26	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	22	22	26
27	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	16	16	27
28	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON	35	35	28
29	V	5	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC.	COMMON			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			\$			\$ 30,512	\$ * 30,512	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

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

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: 10/1/2019 Ending: 9/30/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHRISTINA GIARDINA	PRESIDENT			NONE	2	5.00	SALARY	\$ 2,716	17.7	1
2	MARY SCHAPER	SECRETARY			NONE	2	5.00	SALARY	2,278	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	\$ 4,994		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:

10/1/2019Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

COMMUNITY CARE CENTERS, INC.

Street Address

312 SOLLEY DRIVE - REAR

City / State / Zip Code

BALLWIN, MO 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				\$	\$	4,970,664	\$	1
2	ST GENEVIEVE CARE CTR						3,302,519		2
3	CCC OF LEMAY						3,307,578		3
4	SALEM CARE CENTER						2,248,338		4
5	MONMOUTH NH						2,904,271		5
6	MAR-KA NH						2,966,609		6
7	CCC OF SENECA						3,148,320		7
8	MT VERNON PLACE CARE						2,814,763		8
9	COUNTRY VIEW NH						3,012,820		9
10	MERAMEC NH						3,333,641		10
11	SEVILLE CARE CENTER						3,412,084		11
12	SALEM RES CARE						699,282		12
13	CARL JUNCTION RES CARE						780,447		13
14	MT VERNON RES CARE						488,045		14
15	SENECA HOME PLACE						556,561		15
16	HUDSON HOUSE						630,720		16
17	MAPLE GROVE LODGE						3,557,600		17
18	CCC OF AURORA						4,532,471		18
19	BARRY COMMUNITY CARE						3,591,838		19
20	LICKING RESIDENTIAL CTR						412,537		20
21	CCC OF GAINESVILLE						3,182,324		21
22	AL OF SILVER CREEK						952,822		22
23	MARK TWAIN MANOR						6,304,701		23
24	UNION CARE CENTER						2,236,036		24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/2019Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

COMMUNITY CARE CENTERS, INC.

Street Address

312 SOLLEY DRIVE - REAR

City / State / Zip Code

BALLWIN, MO 63201

Phone Number

(636) 394-3000

Fax Number

(636) 394-7713

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	COMMUNITY IN HOME				\$	\$	801,553	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979

Report Period Beginning:

10/1/2019Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MONMOUTH NURSING HOME# 0027979 Report Period Beginning: 10/1/2019 Ending: 10/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	CENTRAL BANK OF ST LOUIS		X	PPP LOAN		4/20/20	\$ 338,142	\$ 338,142	10/20/21	1.0000	\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MISC INTEREST		X									6
7												7
8												8
9	TOTAL Facility Related						\$ 338,142	\$ 338,142			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 338,142	\$ 338,142			\$	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.)

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONMOUTH NURSING HOME COUNTY WARREN

FACILITY IDPH LICENSE NUMBER 0027979

CONTACT PERSON REGARDING THIS REPORT CAMILLE B. LOCKHART

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 09-532-008-00	LOTS 6, 7, 9, 10 & 11 BLOCK 2	\$ 40,949.50	\$ 40,949.50
2.	SUNSET VIEW ADDN	\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 40,949.50	\$ 40,949.50

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONMOUTH NURSING HOME COUNTY WARREN
FACILITY IDPH LICENSE NUMBER 0027979
CONTACT PERSON REGARDING THIS REPORT CAMILLE B. LOCKHART
TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

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	FACILITY	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:

10/1/2019

Ending:

9/30/2020**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	\$ 6,698	\$	\$	4
5				1990	653,401	6,698	3-30	6,698			5
6											6
7											7
8											8
	Improvement Type**										
9	DRAPERY AND CUBICAL(\$4,570 removed per 2015 desk audit)			1991							9
10	ROOF REPAIRS(\$3,181 removed per 2015 desk audit)			1992							10
11	CARPETING(\$4,074 removed per 2015 desk audit)			1992							11
12	CARPETING(\$4,411 removed per 2015 desk audit)			1993							12
13	ROOF REPAIRS(\$1,380 removed per 2015 desk audit)			1996							13
14	ALARM			1997	7,078		15			7,078	14
15	NURSE CALL SYSTEM			2000	7,347		10			7,347	15
16	FIRE ALARM SYSTEM			2001	2,587		10			2,587	16
17	HOT WATER HEATER(\$2,712 removed per 2015 desk audit)			2001							17
18	DOOR			2002	5,112		20			5,112	18
19	BLACKTOP DRIVEWAYS \$8,651 - desk audit adj off)			2002			8				19
20	MIXING VALVE ON WATER			2002	987		20			987	20
21											21
22	FIXTURES			2002	3,231		10			3,231	22
23	ROOF OVER KITCHEN-Disposal 2019			2002							23
24	WHIRLPOOL TUB (orig \$10,829-desk audit adj to \$953)			2003	953		10			953	24
25	GUTTERS			2003	1,000		10			1,000	25
26	RACKS FOR ROOMS			2003	1,526		10			1,526	26
27	WATER HEATER(\$2,022 removed per 2015 desk audit)			2003							27
28	SIDEWALKS			2004	1,350		15			1,350	28
29	EAST SIDEWALKS			2004	1,200		15			1,200	29
30	HOPPER			2003	3,274		20			3,274	30
31	4 VINYL WINDOWS			2004	1,153		Life of Lease			1,153	31
32	CARPET/SUBFLOOR (removed 17,453 per 2015 audit) (orig \$20,011; adj t			2005			Life of Lease				32
33	SMOKE DAMPER			2005	1,440		Life of Lease			1,440	33
34	WANDERGUARD SYSTEM			2005	8,249		Life of Lease			8,249	34
35	MAIN ROOF (\$25,000 desk audit adj off)			2005			Life of Lease				35
36	GRAVEL FOR SIDE PARKING LOT (\$1,102 desk audit adj off)			2006			Life of Lease				36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	COURTYARD ROOF (\$1,178 desk audit adj off)	2007	\$	\$	Life of Lease	\$	\$	\$	37
38	AMANA HEAT PUMP (\$1,815 removed 2012 desk audit)	2007			Life of Lease				38
39	BOILER VALVE & PUMP (\$1,508 removed 2012 desk audit)	2007			Life of Lease				39
40	ELECTRICAL WORK (\$2,020 removed 2012 desk audit)	2008			Life of Lease				40
41	2 ADDL WG MONITORS (\$2,563 moved to Equip-2012 desk audit)	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(\$3,776 removed per 2015 desk audit)	2009							44
45	RAILINGS	2009	2,684		Life of Lease			2,684	45
46	REPLACE OUTSIDE DOORS DR & KT	2010	4,478		Life of Lease			4,478	46
47	MIXING VALVE ON MAIN SHOWER RM \$1,334 removed 2012 desk audit	2011			Life of Lease				47
48	REPLACE COLD WATER PIPE BSMT (\$1,102 removed 2012 desk audit)	2011			Life of Lease				48
49	UPGRADE ALARM SYSTEM (\$1,238 removed 2012 desk audit)	2011			Life of Lease				49
50	NEW ROOF-Disposal 2019	2011							50
51	OFFICE FURNACE & A/C	2011	5,800		Life of Lease			5,800	51
52	RESTORING WASH HOUSE (\$2,485 removed 2012 desk audit)	2011			Life of Lease				52
53	3 WATER HEATERS (\$13,203 adj to \$12,645 at 2012 desk audit)	2012	12,645		Life of Lease			12,645	53
54	STORM WATER DRAIN	2012	4,500		Life of Lease			4,500	54
55	2 4-TON CONDENSERS	2012	5,400		Life of Lease			5,400	55
56	REPLACE FIRE ALARM SYSTEM(removed \$1,553 2015 desk audit)	2013	9,222		Life of Lease			9,222	56
57	NRS STATION REMODEL-CONTR (\$5,511 removed 2015 desk audit)	2013							57
58	INSTALL NEW WINDOW(\$1,594 removed per 2015 Desk Audit)	2013							58
59	REPLACE PIPES IN ATTIC	2013	5,988		Life of Lease			5,988	59
60	NEW ROOF-Disposal 2019	2013							60
61	SPRINKLER HEADS	2013	25,456		Life of Lease			25,456	61
62	Carpet Halls 1,2,3 & Blue RM-Contract-Scott Harrison(changed vendor)	2011	36,551		Life of Lease			36,551	62
63	TILE HALL BATHROOMS - CONTRACT-SCOTT HARRISON INC	2013	3,726		Life of Lease			3,726	63
64	PAINT ENTIRE FACILITY - CONTRACT -LEWIS W SMITH/LO	2013	8,543		Life of Lease			8,543	64
65	CUBICLE CURTAINS ALL ROOMS/DRAPERIES - CONTRACT	2013	6,847		Life of Lease			6,847	65
66	SPRINKLER SYSTEM PIPES & SPRINKLER WORK	2014	40,139		Life of Lease			40,139	66
67	EXTERIOR WORK	2014	3,813		Life of Lease			3,813	67
68	VINYL FENCING-150 FT	2014	5,600		Life of Lease			5,600	68
69	2 FURNACES & 2 A/C CONDENSING UNITS	2014	10,685		Life of Lease			10,685	69
70	TOTAL (lines 4 thru 69)		\$ 1,307,427	\$ 6,698		\$ 6,698	\$	\$ 238,564	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 1,307,427	\$ 6,698		\$ 6,698	\$	\$ 238,564	1
2	100-GAL A O SMITH WATER HEATER	2014	3,187		Life of Lease			3,187	2
3	2.5-TON A/C FOR KITCHEN(\$1,595 removed per 2015 Desk Audi	2014			Life of Lease				3
4	RPZ ON FIRE MAIN	2015	4,979		Life of Lease			4,979	4
5	WANDERGUARD PLUS 4 SIGNALLING DEVICES(\$1,503 remo	2015			Life of Lease				5
6	OLYMPIAN NATURAL GAS GENERATOR	2015	22,550		Life of Lease			22,550	6
7	50-GALLON WATER HEATER FOR STORAGE ROOM(\$973 re	2015			Life of Lease				7
8	GAS LINE	2015	2,410		Life of Lease			2,410	8
9	CONCRETE WORK	2017	11,540		Life of Lease			11,540	9
10	REPLACE WALL BEHIND DISH MACHINE	2017	2,800		Life of Lease			2,800	10
11	KITCHEN SINK W/ FAUCET	2017	1,411		Life of Lease			1,411	11
12	KITCHEN FLOOR	2017	9,934		Life of Lease			9,934	12
13	DOOR MONITOR FOR WANDERGUARD SYSTEM	2018	1,099		Life of Lease			1,099	13
14	ROOF REPLACEMENT	2019	82,832	16,566	Life of Lease	16,566		28,991	14
15	SPRINKLER SYSTEM	2020	3,556						15
16									16
17	ROUNDING								17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

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	
1	Totals from Page 12C, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	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
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16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,453,725	\$ 23,264		\$ 23,264	\$	\$ 327,465	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$210,178	\$4,675	\$4,675	\$		\$180,461	71
72	Current Year Purchases	14,377	968	968			968	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$224,555	\$5,643	\$5,643	\$		\$181,429	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	\$	\$	\$	4	\$51,341	76
77										77
78										78
79										79
80	TOTALS			\$51,341	\$	\$	\$		\$51,341	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,749,301	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$28,907	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$28,907	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$560,235	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 1,039 Description: Dishwasher lease 158; Kohl lease 881
(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.

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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

☒ 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)	\$					

(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.

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	

(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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10.a2&3	hrs	\$	1,451	\$ 59,340	\$	1,451	\$ 59,340	1
2	Licensed Speech and Language Development Therapist	10.a2&3	hrs		451	18,875		451	18,875	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.a2&3	hrs		1,683	67,419		1,683	67,419	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				39,844		39,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & X-ray	39-02					4,515		4,515	13
14	TOTAL			\$	3,585	\$ 145,634	\$ 44,359	3,585	\$ 189,993	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.

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	\$ 771,083	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	305,110		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,000		5
6	Prepaid Insurance	28		6
7	Other Prepaid Expenses	22,580		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>MCR SETTL; DUE CCC</u>	11,528		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,111,329	\$	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	436,048		15
16	Equipment, at Historical Cost	271,661		16
17	Accumulated Depreciation (book methods)	(607,186)		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): <u>DEPOSITS</u>	7,703		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 108,226	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,219,555	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 260,775	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,551		28
29	Short-Term Notes Payable	205,378		29
30	Accrued Salaries Payable	122,120		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,677		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,364		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>RENT PAY; INTERCO</u>	334,872		36
37	<u>INSURANCE PAYABLE</u>	25,183		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,013,920	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	132,764		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>COVID DEF REV</u>	335,934		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 468,698	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,482,618	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (263,063)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,219,555	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (96,920)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (96,920)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	230,686	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	(122,712)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PPAs: Dist (184,000); Addl Pd Cap 53,100	(130,900)	15
16	Other (describe) PPAs: Bad Debts (142,917); Misc (300)	(143,217)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (166,143)	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)	\$ (263,063)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MONMOUTH NURSING HOME

0027979

Report Period Beginning: 10/1/2019

Ending:

9/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,941,688	1
2	Discounts and Allowances for all Levels	(3,751,544)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,190,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	821,111	6
7	Oxygen	80,836	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 901,947	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	411	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	80	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)	\$ 491	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,065	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,065	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INC/TRANSP/COVID INCOME	62,479	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,479	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,156,126	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	655,073	31
32	Health Care	1,339,610	32
33	General Administration	603,848	33
	B. Capital Expense		
34	Ownership	156,028	34
	C. Ancillary Expense		
35	Special Cost Centers	44,359	35
36	Provider Participation Fee	126,522	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,925,440	40
41	Income before Income Taxes (line 30 minus line 40)**	230,686	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 230,686	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,202,876	44
45	Private Pay - Net Inpatient Revenue	947,777	45
46	Medicare - Net Inpatient Revenue	275,604	46
47	Other-(specify) HOSPICE	319,354	47
48	Other-(specify) C/A-PT A ANC, PT B, PY & BAD DEBTS	(555,467)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,190,144	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.

*** 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.

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	1,789	2,038	\$ 62,638	\$ 30.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,787	5,968	164,136	27.50	3
4	Licensed Practical Nurses	13,838	15,152	313,835	20.71	4
5	CNAs & Orderlies	36,504	38,983	482,190	12.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,100	2,248	31,102	13.84	9
10	Activity Assistants	2,096	2,155	19,998	9.28	10
11	Social Service Workers	1,888	2,128	38,888	18.27	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,174	29,718	13.67	13
14	Head Cook	5,514	6,141	73,814	12.02	14
15	Cook Helpers/Assistants	7,889	8,356	85,993	10.29	15
16	Dishwashers					16
17	Maintenance Workers	2,240	2,407	37,996	15.79	17
18	Housekeepers	8,347	9,339	103,856	11.12	18
19	Laundry	6,303	6,696	69,070	10.32	19
20	Administrator	1,795	2,047	81,243	39.69	20
21	Assistant Administrator					21
22	Other Administrative	3,076	3,380	59,441	17.59	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	424	672	8,234	12.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,544	109,884	\$ 1,662,152 *	\$ 15.13	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	189	\$ 7,575	1.3	35
36	Medical Director	96	7,200	9.3	36
37	Medical Records Consultant	16	1,231	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	502	4,564	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	8	275	11.3	44
45	Social Service Consultant	8	275	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	819	\$ 21,120		49

C. CONTRACT NURSES

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

XIX-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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$4,048
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,603 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. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 126,522
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 22%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.