

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0039347

Facility Name: Montgomery Nursing & Rehabilitation Center

Address: South Route 127, P O Box 309 Hillsboro 62049
 Number City Zip Code

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

IDPA ID Number: 37-1323740

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 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) <u>J. Terry Dooling</u>	
	(Title) <u>Treasurer</u>	
Paid Preparer	(Signed) <u>See Accountants Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>J. Terry Dooling Partner</u>	
	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C. 233 East Center Drive, Alton, IL 62002</u>	
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</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**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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>21</u>	Skilled (SNF)	<u>21</u>	<u>7,665</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>80</u>	Intermediate (ICF)	<u>80</u>	<u>29,200</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,315</u>	<u>2,239</u>	<u>3,931</u>	<u>9,485</u>	8
9	SNF/PED					9
10	ICF	<u>12,627</u>	<u>8,530</u>		<u>21,157</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,942</u>	<u>10,769</u>	<u>3,931</u>	<u>30,642</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.12%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

DaycareF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/1994 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 20 and days of care provided 3,931Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Centre # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	177,195	11,592	5,780	194,567		194,567		194,567		1
2	Food Purchase		157,054		157,054		157,054		157,054		2
3	Housekeeping	90,495	11,205		101,700		101,700		101,700		3
4	Laundry	61,680	14,174		75,854		75,854		75,854		4
5	Heat and Other Utilities			91,679	91,679		91,679	507	92,186		5
6	Maintenance	47,131	8,682	38,922	94,735	951	95,686	410	96,096		6
7	Other (specify):* Waste Removal			6,251	6,251		6,251		6,251		7
8	TOTAL General Services	376,501	202,707	142,632	721,840	951	722,791	917	723,708		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,097,643	83,361	21,135	1,202,139	(4,800)	1,197,339		1,197,339		10
10a	Therapy		2,096	205,018	207,114		207,114	1,230	208,344		10a
11	Activities	56,861	4,312	429	61,602	75	61,677		61,677		11
12	Social Services	31,641		1,039	32,680		32,680		32,680		12
13	CNA Training					6,241	6,241	500	6,741		13
14	Program Transportation		3,259		3,259	36	3,295		3,295		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,186,145	93,028	237,221	1,516,394	1,552	1,517,946	1,730	1,519,676		16
	C. General Administration										
17	Administrative	66,775	7,708	180,207	254,690	(2,384)	252,306	(82,188)	170,118		17
18	Directors Fees			60,000	60,000		60,000	(60,000)			18
19	Professional Services			47,014	47,014	1,322	48,336	(35,458)	12,878		19
20	Dues, Fees, Subscriptions & Promotions			48,750	48,750	(679)	48,071	(24,407)	23,664		20
21	Clerical & General Office Expenses	51,386	17,413	54,478	123,277		123,277	14,717	137,994		21
22	Employee Benefits & Payroll Taxes			248,350	248,350		248,350	10,023	258,373		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,217	10,217	(762)	9,455	5,031	14,486		24
25	Other Admin. Staff Transportation							2,740	2,740		25
26	Insurance-Prop.Liab.Malpractice			49,348	49,348		49,348	1,355	50,703		26
27	Other (specify):*										27
28	TOTAL General Administration	118,161	25,121	698,364	841,646	(2,503)	839,143	(168,187)	670,956		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,680,807	320,856	1,078,217	3,079,880		3,079,880	(165,540)	2,914,340		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Montgomery Nursing & Rehabilitation Center #0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			101,061	101,061	101,061	2,883	103,944			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			213,921	213,921	213,921	(23,657)	190,264			32
33	Real Estate Taxes			42,628	42,628	42,628		42,628			33
34	Rent-Facility & Grounds						3,130	3,130			34
35	Rent-Equipment & Vehicles			182	182	182		182			35
36	Other (specify):* Mortgage Ins.			11,614	11,614	11,614		11,614			36
37	TOTAL Ownership			369,406	369,406	369,406	(17,644)	351,762			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation			25	25	25		25			38
39	Ancillary Service Centers		97,783	18,359	116,142	116,142		116,142			39
40	Barber and Beauty Shops		1,165		1,165	1,165		1,165			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			55,298	55,298	55,298		55,298			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		98,948	73,682	172,630	172,630		172,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,680,807	419,804	1,521,305	3,621,916	3,621,916	(183,184)	3,438,732			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(954)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,083)	20		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				18
19	Entertainment	(2,351)	24		19
20	Contributions	(304)	20		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	(19,311)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,821)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,824)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(155,360)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (155,360)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (183,184)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate PAC & Lobbying Dues	\$ (2,326)	20	1
2	Add expense for 2005 CNA exams paid in 2006	500	13	2
3	Eliminate 2006 IDPH license paid in 2005	(995)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	507	0	0	0	0	0	0	0	0	0	507	5
6	Maintenance	0	410	0	0	0	0	0	0	0	0	0	410	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	917	0	0	0	0	0	0	0	0	0	917	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	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	1,230	0	0	0	0	0	0	0	0	1,230	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	500	0	0	0	0	0	0	0	0	0	0	500	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	500	0	1,230	0	0	0	0	0	0	0	0	1,730	16
	C. General Administration													
17	Administrative	0	54,812	(137,000)	0	0	0	0	0	0	0	0	(82,188)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	0	1,293	(36,751)	0	0	0	0	0	0	0	0	(35,458)	19
20	Fees, Subscriptions & Promotions	(25,019)	612	0	0	0	0	0	0	0	0	0	(24,407)	20
21	Clerical & General Office Expenses	0	14,717	0	0	0	0	0	0	0	0	0	14,717	21
22	Employee Benefits & Payroll Taxes	0	10,023	0	0	0	0	0	0	0	0	0	10,023	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,351)	7,382	0	0	0	0	0	0	0	0	0	5,031	24
25	Other Admin. Staff Transportation	0	2,740	0	0	0	0	0	0	0	0	0	2,740	25
26	Insurance-Prop.Liab.Malpractice	0	1,355	0	0	0	0	0	0	0	0	0	1,355	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,370)	92,934	(233,751)	0	0	0	0	0	0	0	0	(168,187)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,870)	93,851	(232,521)	0	0	0	0	0	0	0	0	(165,540)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	2,883	0	0	0	0	0	0	0	0	0	2,883	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(954)	166	(22,869)	0	0	0	0	0	0	0	0	(23,657)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	3,130	0	0	0	0	0	0	0	0	0	3,130	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(954)	6,179	(22,869)	0	(17,644)	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)	(27,824)	100,030	(255,390)	0	(183,184)	45							

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr., Inc.	Jerseyville, IL	Wellington Mgt. Co.	Chesterfield, MO	Management Co.
David L. Kamler	15.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	15.00	Spanish Lake Nursing and Rehabilitation Ctr.	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
Jack Yaeger	10.00			NW Rehab, L.L.C.	Alton, IL	Therapy Co.
				Three Amigos, L.L.C.	Alton, IL	Real Estate Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 See Schedule VIII	\$	Wellington Management Co.	60.00%	\$ 507	\$	507 1
2	V	6 See Schedule VIII		Wellington Management Co.	60.00%	410		410 2
3	V	17 See Schedule VIII		Wellington Management Co.	60.00%	54,812		54,812 3
4	V	19 See Schedule VIII		Wellington Management Co.	60.00%	1,293		1,293 4
5	V	20 See Schedule VIII		Wellington Management Co.	60.00%	612		612 5
6	V	21 See Schedule VIII		Wellington Management Co.	60.00%	14,717		14,717 6
7	V	22 See Schedule VIII		Wellington Management Co.	60.00%	10,023		10,023 7
8	V	24 See Schedule VIII		Wellington Management Co.	60.00%	7,382		7,382 8
9	V	25 See Schedule VIII		Wellington Management Co.	60.00%	2,740		2,740 9
10	V	26 See Schedule VIII		Wellington Management Co.	60.00%	1,355		1,355 10
11	V	30 See Schedule VIII		Wellington Management Co.	60.00%	2,883		2,883 11
12	V	32 See Schedule VIII		Wellington Management Co.	60.00%	166		166 12
13	V	34 See Schedule VIII		Wellington Management Co.	60.00%	3,130		3,130 13
14	Total		\$			\$ 100,030	\$ *	100,030 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	10	Nursing and Medical Records	\$ 19,530	Wellington Management Co.	60.00%	\$ 19,530	\$	15
16	V	17	Management Fees	129,749	Wellington Management Co.	60.00%		(129,749)	16
17	V	17	Management Fees	50,458	Health Care Financial, L.L.C.	40.00%	43,207	(7,251)	17
18	V	19	Professional Services	36,751	C.J. Schlosser & Company, L.L.C.	40.00%		(36,751)	18
19	V	10a	Therapy Services	205,018	NW Rehab, L.L.C.	100.00%	206,248	1,230	19
20	V	32	Interest		Health Care Financial, L.L.C.	40.00%	1,694	1,694	20
21	V	32	Interest	16,963	John H. Rothert	60.00%		(16,963)	21
22	V	32	Interest	3,800	J. Terry Dooling	15.00%		(3,800)	22
23	V	32	Interest	3,800	David L. Kamler	15.00%		(3,800)	23
24	V	18	Director's Fees	36,000	John H. Rothert	60.00%		(36,000)	24
25	V	18	Director's Fees	12,000	J. Terry Dooling	15.00%		(12,000)	25
26	V	18	Director's Fees	12,000	David L. Kamler	15.00%		(12,000)	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		\$ 526,069				\$ 270,679	\$ * (255,390)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cent # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	John H. Rothert	President	Administrative	60.00	214,197	7.2	18.00	Salary	\$ 47,007	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,007		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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 Wellington Management Corporation
 Street Address 750 Spirit 40 Park Drive
 City / State / Zip Code Chesterfield, MO 63005
 Phone Number (636) 537-8447
 Fax Number (636) 537-8446

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs 17,560,580	5	\$ 2,815	\$	3,160,278	\$ 507	1
2	6	Maintenance	Accumulated Costs 17,560,580	5	2,278		3,160,278	410	2
3	17	Administrative	Accumulated Costs 17,560,580	5	304,573	304,573	3,160,278	54,812	3
4	19	Professional Services	Accumulated Costs 17,560,580	5	7,187		3,160,278	1,293	4
5	20	Dues, Fees, Subs & Promos	Accumulated Costs 17,560,580	5	3,399		3,160,278	612	5
6	21	Clerical and General Office Exp	Accumulated Costs 17,560,580	5	81,778	46,280	3,160,278	14,717	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs 17,560,580	5	55,695		3,160,278	10,023	7
8	24	Travel and Seminar	Accumulated Costs 17,560,580	5	41,017		3,160,278	7,382	8
9	25	Other Admin Staff Transport	Accumulated Costs 17,560,580	5	15,223		3,160,278	2,740	9
10	26	Insurance-Prop, Liab, Malprac.	Accumulated Costs 17,560,580	5	7,527		3,160,278	1,355	10
11	30	Depreciation	Accumulated Costs 17,560,580	5	16,019		3,160,278	2,883	11
12	32	Interest	Accumulated Costs 17,560,580	5	920		3,160,278	166	12
13	34	Rent-Facility and Ground	Accumulated Costs 17,560,580	5	17,395		3,160,278	3,130	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				\$ 555,826	\$ 350,853		\$ 100,030	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cente # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	GMAC Commercial Mortgage		X	Refinance Mortgage	\$17,016.17	9/29/99	\$ 2,415,500	\$ 2,311,720	10/1/34	7.9200	\$ 183,966	1						
2	Ford Credit		X	Van Loan	\$596.16	3/15/04	33,260	21,619	3/14/09	2.9000	728	2						
3											4,664	3						
4											(954)	4						
5											166	5						
Working Capital																		
6	Health Care Financial	X		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.5000	1,694	6						
7												7						
8	First National Bank		X	Line of Credit	N/A	1/4/05	100,000	1	1/4/06	prime+1%		8						
9	TOTAL Facility Related				\$17,612.33		\$ 2,628,760	\$ 2,413,340			\$ 190,264	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,628,760	\$ 2,413,340			\$ 190,264	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,614 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing & Rehabilitation Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-100-716-75</u>	<u>NE PT SE SW Land Corp Limit</u>	\$ <u>38,628.22</u>	\$ <u>38,628.22</u>
2. _____	<u>Taylor Springs</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>38,628.22</u>	\$ <u>38,628.22</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347

Report Period Beginning:

01/01/2005 Ending:12/31/2005**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>348,480</u>	<u>1994</u>	<u>\$ 27,673</u>	1
2					2
3	TOTALS	348,480		\$ 27,673	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Montgomery Nursing & Rehabilitation Center**# **0039347**

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

	1 Beds*	FOR OHF 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	101		1994		\$ 962,086	\$ 38,483	25	\$ 38,483	\$	\$ 452,180	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed		1994		3,247		10			3,247	9
10	Air Conditioner		1994		76,140		10			76,140	10
11	Cabinets		1994		6,809	340	20	340		3,830	11
12	Doors		1994		2,337	117	20	117		1,324	12
13	Electrical		1994		4,601	230	20	230		2,564	13
14	Flooring		1994		25,850		10			25,850	14
15	Exterior Remodeling		1994		4,468	298	15	298		3,376	15
16	Interior Remodeling		1994		66,214	4,386	15	4,386		49,360	16
17	Nurse Call System		1994		1,960	131	15	131		1,470	17
18	Plumbing		1994		6,619	331	20	331		3,715	18
19	Roof		1994		29,619		10			29,619	19
20	Windows/Gutter		1994		60,254	4,017	15	4,017		45,860	20
21	Siding		1994		15,818	1,055	15	1,055		11,674	21
22	Landscaping		1994		3,134		10			3,134	22
23	Parking Lot		1994		29,107		10			29,107	23
24	Home Office Wallpapering/Flooring		1994		2,846		5			2,846	24
25	Flooring		1995		938		10			938	25
26	Metal Doors and Frames		1996		953	48	20	48		453	26
27	Metal Carport		1997		972	65	15	65		535	27
28	Carpet		1997		2,310		5			2,310	28
29	Dining Room Chair Rail		1997		2,230	149	15	149		1,189	29
30	Wallpapering		1997		4,830		5			4,830	30
31	Fire Doors		1997		593	30	20	30		237	31
32	Foliage & Fountains		1997		1,657	166	10	166		1,450	32
33	Interior Painting		1997		514		5			514	33
34	Shed		1997		315	32	10	32		255	34
35	Door Alarm System		1997		7,840	784	10	784		6,338	35
36											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	Sidewalk Replacement	1997	\$ 650	\$ 43	15	\$ 43	\$	\$ 350	37
38	Beauty Shop Remodeling	1998	4,287	214	20	214		1,554	38
39	Wallpapering	1998	1,493		5			1,493	39
40	Shower Room Remodeling	1998	1,199	60	20	60		440	40
41	Mini Blinds Installed	1998	509	51	10	51		402	41
42	Shelving	1998	566	28	20	28		210	42
43	Baseboard Remodeling	1998	820	82	10	82		649	43
44	Water Heater	1998	6,040	403	15	403		2,919	44
45	Folding Doors	1998	456	46	10	46		330	45
46	Door Installed	1998	208	21	10	21		149	46
47	Wall Mounted Laundry Tub	1998	181	9	20	9		72	47
48	Shower Flooring	1998	401	40	10	40		284	48
49	Shed	1998	185	19	10	19		131	49
50	Flooring	1998	293	29	10	29		217	50
51	Air Conditioning Unit	2000	557	56	10	56		311	51
52	Asphalt Parking Lot	2000	2,360	236	10	236		1,259	52
53	Fire Doors	2001	1,534	102	15	102		469	53
54	Signage	2001	3,318	663	5	663		3,041	54
55	Cove Base	2001	1,006	101	10	101		459	55
56	Window Treatments	2001	7,272	1,454	5	1,454		6,666	56
57	Wallpapering	2001	37,693	7,539	5	7,539		34,504	57
58	Lobby Carpet	2001	1,433	287	5	287		1,337	58
59	Air Conditioning Unit	2001	1,696	170	10	170		763	59
60	Home Office Wallpapering	1999	479		5			479	60
61	Cove Base	2002	604	60	10	60		191	61
62	Wallpapering	2002	4,462	892	5	892		3,339	62
63	Air Conditioning Unit	2002	1,981	198	10	198		727	63
64	Blinds	2002	512	102	5	102		401	64
65	Flooring & Cove Base	2002	1,630	163	10	163		638	65
66	Wall Guard	2002	1,927	128	15	128		492	66
67	Fire Doors	2002	1,042	69	15	69		243	67
68	A/C/ Heat Pump Units	2002	1,580	158	10	158		540	68
69	Home Office Light Fixtures	2002	173		10	18	18	67	69
70	TOTAL (lines 4 thru 69)		\$ 1,412,808	\$ 64,085		\$ 64,103	\$ 18	\$ 829,471	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,412,808	\$ 64,085		\$ 64,103	\$ 18	\$ 829,471	1
2	Air Conditioning Unit	2003	3,110	311	10	311		740	2
3	11 Fire Doors	2003	5,950	397	15	397		892	3
4	Home Office Cabinets	2003	751		10	75	75	188	4
5	Closet Doors-Resident Rooms	2004	3,628	242	15	242		365	5
6	Wiring Outside Lights	2004	1,145	57	20	57		110	6
7	Tile	2004	878	88	10	88		168	7
8	Commercial Water Heater	2004	7,664	766	10	766		1,150	8
9	Floor Tile	2004	1,186	119	10	119		129	9
10	66 Gallon Water Heater	2004	931	93	10	93		101	10
11	Patio & Sidewalks	2004	14,316	954	15	954		1,273	11
12	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		152	12
13	Gravel Parking Lot	2004	3,355	671	5	671		1,174	13
14	Range Hood	2005	831	41	20	41		41	14
15	Closet Doors-Resident Rooms	2005	3,689	286	10	286		286	15
16	Outside Light Fixtures	2005	2,025	145	10	145		145	16
17	Air Conditioning Units	2005	7,609	351	10	351		351	17
18	Generator Wiring	2005	1,660	166	5	166		166	18
19	Electrical Work	2005	5,528	138	20	138		138	19
20	Tile & Cove Base	2005	2,064	87	10	87		87	20
21	Heating/Cooling Unit	2005	558	46	5	46		46	21
22	Wallpaper	2005	810	40	5	40		40	22
23	Therapy Room Cabinets	2005	1,200		15				23
24	New Roof-200 & 500 Wings	2005	74,745	1,246	15	1,246		1,246	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)		\$ 1,557,961	\$ 70,430		\$ 70,523	\$ 93	\$ 838,459	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 188,541	\$ 20,075	\$ 21,093	\$ 1,018	5-20	\$ 89,069	71
72	Current Year Purchases	6,557	247	248	1	5-15	248	72
73	Fully Depreciated Assets	310,069	1,359	1,359		5-10	310,069	73
74								74
75	TOTALS	\$ 505,167	\$ 21,681	\$ 22,700	\$ 1,019		\$ 399,386	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2004 Ford Wheelchair Van	2004	\$ 35,799	\$ 8,950	\$ 8,950		4	\$ 16,408	76
77	Home Office-Admin	2000 Ford Taurus	2000	4,286				4	4,286	77
78	Home Office-Admin	1998 Jaguar	2004	4,044		1,011	1,011	4	1,517	78
79	See Schedule Attached			3,266		760	760	4	1,303	79
80	TOTALS			\$ 47,395	\$ 8,950	\$ 10,721	\$ 1,771		\$ 23,514	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)	\$ 2,138,196	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,944	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,883	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,261,359	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	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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?

N/A YES N/A NO

16. Rental Amount for movable equipment: \$ 182 Description: Ice machines \$146; Gas Tank \$36

(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	<u>Section Not Applicable</u>		\$	\$	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 Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		511		511
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		4,800		4,800
6	Transportation				
7	Contractual Payments		380		380
8	CNA Competency Tests		1,050		1,050
9	TOTALS	\$	\$ 6,741	\$	\$ 6,741
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,741		

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	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	22

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	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	10a,8	2840 hrs	\$ 84,607		\$	\$	2,840	\$ 84,607	1
2	Licensed Speech and Language Development Therapist	10a,8	966 hrs	37,742				966	37,742	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	2746 hrs	83,899			2,096	2,746	85,995	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				97,783		97,783	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees	39,3				16,389			16,389	
	Other (specify): X-Rays	39,3				1,970			1,970	13
14	TOTAL			\$ 206,248		\$ 18,359	\$ 99,879	6,552	\$ 324,486	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (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	\$ 49,397	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 25,842)	653,776		3
4	Supply Inventory (priced at cost)	15,283		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,742		6
7	Other Prepaid Expenses	2,176		7
8	Accounts Receivable (owners or related parties)	10,179		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 764,553	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	82,116		13
14	Buildings, at Historical Cost	1,499,271		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	528,502		16
17	Accumulated Depreciation (book methods)	(1,241,268)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	35,373		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	134,079		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,068,373	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,832,926	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 576,444	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,305		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,402		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Due to Related Parties</u>	317,850		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,042,001	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	214,412		39
40	Mortgage Payable	2,311,720		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)	\$ 2,526,132	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,568,133	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,735,207)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,832,926	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,702,486)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,702,486)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(32,721)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (32,721)	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)	\$ (1,735,207)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,417,710	1
2	Discounts and Allowances for all Levels	(319,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,098,087	3
B. Ancillary Revenue			
4	Day Care	930	4
5	Other Care for Outpatients		5
6	Therapy	410,482	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 411,412	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,848	11
12	Gift and Coffee Shop	966	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	66,467	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76,281	23
D. Non-Operating Revenue			
24	Contributions	675	24
25	Interest and Other Investment Income***	954	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,629	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	1,786	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,786	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,589,195	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	721,840	31
32	Health Care	1,516,394	32
33	General Administration	841,646	33
B. Capital Expense			
34	Ownership	369,406	34
C. Ancillary Expense			
35	Special Cost Centers	117,332	35
36	Provider Participation Fee	55,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,621,916	40
41	Income before Income Taxes (line 30 minus line 40)**	(32,721)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (32,721)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See attached 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

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	2,254	2,254	\$ 53,528	\$ 23.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,380	6,586	127,713	19.39	3
4	Licensed Practical Nurses	18,862	19,912	308,816	15.51	4
5	CNAs & Orderlies	65,818	69,076	576,853	8.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,579	5,891	56,861	9.65	10
11	Social Service Workers	1,986	2,240	31,641	14.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,120	22,504	177,195	7.87	15
16	Dishwashers					16
17	Maintenance Workers	4,000	4,296	47,131	10.97	17
18	Housekeepers	10,660	11,845	90,495	7.64	18
19	Laundry	9,084	9,431	61,680	6.54	19
20	Administrator	2,080	2,080	66,775	32.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,061	4,304	51,386	11.94	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	2,288	2,401	30,733	12.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,172	162,820	\$ 1,680,807 *	\$ 10.32	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	116	\$ 5,780	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	12	597	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,008	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	7	429	11,3	44
45	Social Service Consultant	16	1,039	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	19,530	10,3	47
48					48
49	TOTAL (lines 35 - 48)	151	\$ 37,983		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center**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. Illinois Health Care Association \$3,744
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,798 Line 10
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,298
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? None
- (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. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 17.8%
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? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Hughes & Associates, CPA, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/05

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(679)
NURSE AIDE TRAINING	13	679
To reclass expenses for CNA class books & test fees to proper line		
ADMINISTRATIVE	17	(2,384)
MAINTENANCE	6	951
ACTIVITIES	11	75
PROGRAM TRANSPORTATION	14	36
PROFESSIONAL SERVICES	19	1,322
To reclass maintenance supplies, activities supplies, program transportation & professional services to proper lines		
NURSE AIDE TRAINING	13	762
TRAVEL & SEMINAR	24	(762)
To reclass CNA class evaluator, books, & test fees to proper line		
NURSE AIDE TRAINING	13	4,800
NURSING & MEDICAL RECORDS	10	(4,800)
To reclass CNA trainer wages		

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/05

Miscellaneous Income	46
Seniorcise Program	<u>1,740</u>
	<u><u>1,786</u></u>

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2005

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Birdie Scroggins & Ginny Turner	Activities Director & Assistant	10/20-10/21/05	Mt. Auburn, IL	2005 IAPA Conference	IAPA	380	191
Tammy Richmond & Birdie Scroggins	Social Services Director & Activities Director	4/6-4/7/05	Springfield, IL	SSPI Annual Convention	Outcome Services	171	219
Ramona Tomazzoli & Deb Schulte	Director of Nursing & Asst. Director of Nursing	4/6-4/7/05	Springfield, IL	Resources for Success	IHCA	325	133
Ramona Tomazzoli	Director of Nursing	5/19/05	Springfield, IL	Integra Healthcare Education	Integra Healthcare	149	
Lesley Brown	Business Office Manager	6/20/05	St. Louis, MO	How to Legally Collect Accounts Receivable	Padgett-Thompson	179	
Candy Jones	CNA	6/15-6/18/05	Springfield, IL	Rehabilitation Aide Training	Lincoln Land Community College	375	165
Ramona Tomazzoli	Director of Nursing	6/24/2005	Springfield, IL	Managing Multiple Priorities	Fred Pryor Seminars	149	
Carla Vonderhaar & Lesley Brown	Administrator & Business Office Manager	10/19/2005	Springfield, IL	Medicare Part D - Part II	Illinois Healthcare Association	190	
						1,918	708
					Total Seminar Lodging/Travel/Meals	708	
					CPR Training	10	
					Other Travel Expense <\$250	4,468	
					Home Office Travel & Seminar	7,382	
					Total Travel & Seminar, Line 24	14,486	

Montgomery Nursing & Rehabilitation Center
Attachment to Sch. XI, Part D
December 31, 2005

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make & Year</u>	<u>Year</u> <u>Acquired</u>	<u>Cost</u>	<u>Current Book</u> <u>Depreciation</u>	<u>Straight Line</u> <u>Depreciation</u>	<u>Adjustments</u>	<u>Life in</u> <u>Years</u>	<u>Accumulated</u> <u>Depreciation</u>
2001 Infiniti	2004	2,366	0	591	591	4	1,134
2000 Dodge Caravan	2005	900	0	169	169	4	169
		<u>3,266</u>	<u>0</u>	<u>760</u>	<u>760</u>		<u>1,303</u>

Montgomery Nursing & Rehabilitation Center
Attachment to Sch. XVII
December 31, 2005

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	(32,721)
DEPRECIATION ADJUSTMENT	(44,002)
MISC. NON-DEDUCTIBLE EXPENSES	6,098
CONVERSION TO CASH BASIS ADJUSTMENTS	78,010
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>7,385</u></u>