

		FOR BHF USE					

LL1

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: 0037515

Facility Name: Montgomery Place

Address: 5550 South Shore Drive Chicago 60637
 Number City Zip Code

County: Cook

Telephone Number: (773)753-4100 **Fax #** (773)752-0056

HFS ID Number: 363582046001

Date of Initial License for Current Owners: 01/24/92

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" 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 <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input 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: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Andrew B. Cutler</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</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 Place

0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	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			4,181	4,181	8
9	SNF/PED					9
10	ICF	3,549	16,823	742	21,114	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,549	16,823	4,923	25,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.52%

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

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

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

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 1/28/92

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 14 and days of care provided 4,181

Medicare Intermediary Cahaba GBA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/05 Fiscal Year: 6/30/05

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	381,779	50,082	2,146	434,007		434,007	(20,400)	413,607			1
2	Food Purchase		420,845		420,845	(45,169)	375,676	(150,140)	225,536			2
3	Housekeeping	62,458	27,860	10,159	100,477		100,477	(27,603)	72,874			3
4	Laundry	37,703	6,501		44,204		44,204		44,204			4
5	Heat and Other Utilities			303,148	303,148		303,148	(220,091)	83,057			5
6	Maintenance	127,675	48,500	248,790	424,965		424,965	(159,310)	265,655			6
7	Other (specify):*											7
8	TOTAL General Services	609,615	553,788	564,243	1,727,646	(45,169)	1,682,477	(577,544)	1,104,933			8
	B. Health Care and Programs											
9	Medical Director			29,928	29,928		29,928		29,928			9
10	Nursing and Medical Records	1,387,968	81,895	1,453	1,471,316		1,471,316	(247)	1,471,069			10
10a	Therapy											10a
11	Activities	79,550	12,268	2,110	93,928		93,928	(1,296)	92,632			11
12	Social Services	19,563			19,563		19,563		19,563			12
13	CNA Training											13
14	Program Transportation	29,733	303		30,036		30,036	(17,681)	12,355			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,516,814	94,466	33,491	1,644,771		1,644,771	(19,224)	1,625,547			16
	C. General Administration											
17	Administrative	262,805			262,805		262,805		262,805			17
18	Directors Fees											18
19	Professional Services			248,512	248,512		248,512	(151,683)	96,829			19
20	Dues, Fees, Subscriptions & Promotions			44,721	44,721		44,721	(22,726)	21,995			20
21	Clerical & General Office Expenses	72,150	31,888	373,369	477,407		477,407	(370,220)	107,187			21
22	Employee Benefits & Payroll Taxes			1,031,767	1,031,767	45,169	1,076,936	(325,515)	751,421			22
23	Inservice Training & Education											23
24	Travel and Seminar			26,602	26,602		26,602	(18,109)	8,493			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			367,289	367,289		367,289	(266,659)	100,630			26
27	Other (specify):*											27
28	TOTAL General Administration	334,955	31,888	2,092,260	2,459,103	45,169	2,504,272	(1,154,912)	1,349,360			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,461,384	680,142	2,689,994	5,831,520		5,831,520	(1,751,680)	4,079,840			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 Place #0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			1,097,654	1,097,654		1,097,654	(978,094)	119,560			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,893	1,893		1,893	343,605	345,498			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,718	31,718		31,718	(16,030)	15,688			35
36	Other (specify):*											36
37	TOTAL Ownership			1,131,265	1,131,265		1,131,265	(650,519)	480,746			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,414	365,034	495,448		495,448		495,448			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*	175,772	3,618	1,464,507	1,643,897		1,643,897	(1,643,897)				43
44	TOTAL Special Cost Centers	175,772	134,032	1,880,459	2,190,263		2,190,263	(1,643,897)	546,366			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,637,156	814,174	5,701,718	9,153,048		9,153,048	(4,046,096)	5,106,952			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 Place

0037515

Report Period Beginning: 07/01/04

Ending: 06/30/05

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	(6,634)	02		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	261	30		9
10	Interest and Other Investment Income	(78,567)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(10,667)	21		19
20	Contributions	(250)	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	(27,355)	21		24
25	Fund Raising, Advertising and Promotional				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	(3,922,884)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,046,096)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (4,046,096)		37

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

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

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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Place ID# 0037515
 Report Period Beginning: 07/01/04
 Ending: 06/30/05

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Miscellaneous Service Revenue	\$ (12,322)	21	1
2 Transportation Revenue	(17,528)	14	2
3 Other Miscellaneous Revenue	(64,348)	21	3
4 Medical Record Sales	(247)	10	4
5 Church Home Admin. Fee	(16,000)	21	5
6 Gain on Disposal of Assets	(920)	06	6
7 Marketing & Independent Living Expenses	(847,756)	43	7
8 Land Fees / Service Charges	(17,724)	21	8
9 Bank Charges	(209,000)	21	9
10 Activity Fundraisers Revenue	(1,206)	11	10
11 Non-Care Depreciation	(978,355)	30	11
12 Non-Allowable Legal Fees	(57,746)	19	12
13 Out of State Travel	(9,431)	24	13
14 Capitalized R&M	(17,397)	6	14
15 Imprest Income	(337,701)	32	15
16 INDEPENDENT LIVING:			
17 Dining	(20,400)	1	17
18 Food	(143,580)	2	18
19 Housekeeping	(7,604)	3	19
20 Utilities	(120,091)	5	20
21 Maintenance	(140,993)	6	21
22 Transportation	(153)	14	22
23 Professional Fees	(98,943)	19	23
24 Fees, Subs. & Promotions	(22,476)	20	24
25 Office Expense	(35,801)	21	25
26 Employee Benefits	(353,514)	25	26
27 Travel & Seminar	(8,678)	24	27
28 Insurance	(266,659)	26	28
29 Income	(914,529)	32	29
30 Rent - Equip & Vehicles	(46,030)	35	30
31 Independent Living	(796,141)	43	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			49
50			50
51			51
52			52
53			53
54			54
55			55
56			56
57			57
58			58
59			59
60			60
61			61
62			62
63			63
64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(3,922,884)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05**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	(20,400)											(20,400)	1
2	Food Purchase	(150,140)											(150,140)	2
3	Housekeeping	(27,603)											(27,603)	3
4	Laundry													4
5	Heat and Other Utilities	(220,091)											(220,091)	5
6	Maintenance	(159,310)											(159,310)	6
7	Other (specify):*													7
8	TOTAL General Services	(577,544)											(577,544)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(247)											(247)	10
10a	Therapy													10a
11	Activities	(1,296)											(1,296)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation	(17,681)											(17,681)	14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(19,224)											(19,224)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(151,683)											(151,683)	19
20	Fees, Subscriptions & Promotions	(22,726)											(22,726)	20
21	Clerical & General Office Expenses	(370,220)											(370,220)	21
22	Employee Benefits & Payroll Taxes	(325,515)											(325,515)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(18,109)											(18,109)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(266,659)											(266,659)	26
27	Other (specify):*													27
28	TOTAL General Administration	(1,154,912)											(1,154,912)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,751,680)											(1,751,680)	29

STATE OF ILLINOIS

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/04

Ending:

Summary B

06/30/05

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS (to Sch V, col.7)										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(978,094)											(978,094)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	343,605											343,605	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles	(16,030)											(16,030)	35
36	Other (specify):*													36
37	TOTAL Ownership	(650,519)											(650,519)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,643,897)											(1,643,897)	43
44	TOTAL Special Cost Centers	(1,643,897)											(1,643,897)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(4,046,096)											(4,046,096)	45

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

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									\$		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	\$		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 Place

0037515

Report Period Beginning: 07/01/04

Ending: 06/30/05

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 Montgomery Place Independent Living
 Street Address 5550 South Shore Drive
 City / State / Zip Code Chicago, Illinois 60637
 Phone Number (773) 753-4100
 Fax Number (773) 752-0056

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	119,605	\$ 52,228	\$	72,885	\$ 31,827	1
2	2	Food	Meals	119,605	367,400		72,885	223,887	2
3	3	Housekeeping	Square Feet	234,706	38,019		64,305	10,416	3
4	5	Utilities	Square Feet	234,706	303,148		64,305	83,057	4
5	6	Maintenance	Revenue	9,260,340	278,973		4,580,143	137,979	5
6	14	Program Transportation	Revenue	9,260,340	303		4,580,143	150	6
7	19	Professional Fees	Revenue	9,260,340	195,772		4,580,143	96,828	7
8	20	Dues & Subscriptions	Revenue	9,260,340	44,471		4,580,143	21,995	8
9	21	Clerical & General Office	Revenue	9,260,340	70,838		4,580,143	35,036	9
10	22	Employee Benefits	Salaries	3,415,769	1,078,578		2,384,868	753,056	10
11	24	Travel & Seminar	Revenue	9,260,340	17,171		4,580,143	8,493	11
12	26	Insurance	Square Feet	234,706	367,289		64,305	100,630	12
13	30	Depreciation	Actual		119,298			119,298	13
14	32	Interest	Square Feet	234,706	1,261,027		64,305	345,498	14
15	35	Equipment Rental	Revenue	9,260,340	31,718		4,580,143	15,688	15
16	43	Independent Living			2,970,746	971,912			16
17	4	Laundry		1	6,501		1	6,501	17
18	9	Medical Director		1	29,928		1	29,928	18
19	10	Nursing / Medical Records		1	83,101		1	83,101	19
20	11	Activities		1	13,082		1	13,082	20
21	39	Ancillary		1	495,448		1	495,448	21
22	42	Provider Participation Fee		1	50,918		1	50,918	22
23									23
24									24
25	TOTALS				\$ 7,875,957	\$ 971,912		\$ 2,662,816	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/04

Ending: 06/30/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Bank of Scotland		X	Mortgage		3/31/94	\$ 20,000,000	\$ 19,516,640			\$ 1,337,701	1				
2	Less: allocation to Ind. Living										(915,529)	2				
3												3				
4												4				
5	See Supplemental Schedule											5				
Working Capital																
6	Security Deposit		X								1,893	6				
7												7				
8	See Supplemental Schedule											8				
9	TOTAL Facility Related						\$ 20,000,000	\$ 19,516,640			\$ 424,065	9				
B. Non-Facility Related*																
10	Interest Income										(78,567)	10				
11												11				
12												12				
13	See Supplemental Schedule											13				
14	TOTAL Non-Facility Related						\$	\$			\$ (78,567)	14				
15	TOTALS (line 9+line14)						\$ 20,000,000	\$ 19,516,640			\$ 345,498	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

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.)

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1	2		3	4	5	6		7	8	9	10							
		Name of Lender	Related**				Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
			YES											NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2000	_____	8		
2001	_____	9		
2002	_____	10		
2003	_____	11		
2004	_____	12		
			FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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. _____	_____	\$ _____	\$ _____
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 & 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.

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 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 Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

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. _____	_____	\$ _____	\$ _____
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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning:

07/01/04 Ending:

06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,305 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Montgomery Place Retirement Community: 170,401 sq. ft. - 165 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>13,650</u>	<u>1990</u>	<u>\$ 891,425</u>	1
2					2
3	TOTALS	13,650		\$ 891,425	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Montgomery Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1992	1992	\$ 5,735,741	\$		\$	\$	\$ 5,735,741	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1997	20,111		20	2,012	2,012	15,635	9
10	Various			1998	19,268		20	1,850	1,850	13,299	10
11	Various			1999	40,652		20	1,422	1,422	8,283	11
12	Various			2000	143,621		20	11,596	11,596	57,810	12
13	Various			2001	117,397		20	11,099	11,099	53,824	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

*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 Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
		\$	\$		\$	\$	\$	
		6,076,790	119,298		27,979	(91,319)	5,884,592	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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		\$ 6,076,790	\$ 119,298		\$ 27,979	\$ (91,319)	\$ 5,884,592	1
2	Design Lines/Carpeting-East Room	2002	1,162		20	232	232	813	2
3	Dorshy, Hodgson & Partners/Architect	2002	3,360		20	168	168	588	3
4	Design Lines/Replacement Glass-Dinin	2002	78		20	8	8	28	4
5	Design Lines/Painting-1St Floor Offi	2002	59		20	12	12	42	5
6	Design Lines/Dining Room Renovation-	2002	2,657		20	133	133	465	6
7	Dorshy, Hodgson & Partners/Archituct	2002	787		20	39	39	137	7
8	Design Lines/Dining Room Renovation-	2002	1,499		20	75	75	256	8
9	John J. Urbikas & Associates/Elevato	2002	932		20	93	93	287	9
10	Legat Architects/Life Safety Code	2002	1,460		20	146	146	426	10
11	Design L/Vertical Louvers East Rm	2002	81		20	16	16	46	11
12	Design L/Carpeting 2Nd & 3Rd Fl. 50%	2002	9,423		20	1,885	1,885	5,340	12
13	Design L/Walcovering Hc	2002	7,358		20	736	736	2,085	13
14	Acm Elevator/Svc Contract 10-12/02	2002	1,388		20	139	139	393	14
15	Design L/Shipping Garden Furniture	2002	133		20	13	13	37	15
16	Design L/Carpeting 2Nd & 3Rd Fl. 50%	2002	9,423		20	1,885	1,885	5,183	16
17	Design L/Walcovering Hc	2002	7,358		20	736	736	2,024	17
18	Design L/Repair Wall & Ceiling 50%	2002	1,791		20	179	179	478	18
19	Design L/Repair Wall & Ceiling Fnl	2002	1,791		20	179	179	478	19
20	Ward Door/Birch Door	2002	255		20	17	17	45	20
21	Design L/Double Door For New Closet	2002	710		20	47	47	126	21
22	Design L/Sink & Counter/Cabinet	2002	2,932		20	195	195	521	22
23	Design L/Repair & Intall Closet	2002	1,791		20	119	119	318	23
24	Design L/Walcover/Borders	2002	2,289		20	458	458	1,221	24
25	Sherwin Williams/Paint For 2Nd Floor	2002	247		20	49	49	131	25
26	Design/Shipping Charges Hc	2002	1,492		20	149	149	385	26
27	Design L/Walcover/Borders (2)	2002	2,289		20	458	458	1,183	27
28	Design L/Carpet 2Nd Fl (1)	2002	1,586		20	317	317	819	28
29	Design L/Corner Guards (1)	2002	1,500		20	150	150	388	29
30	Design L/Relocate Sprinklers	2002	403		20	40	40	104	30
31	Design L/Installation Cabinet/C Tbl	2002	438		20	88	88	227	31
32	Design L/Carpet Base 2Nd Fl (2)	2002	1,586		20	317	317	819	32
33	Design L/Wall Prep Covers 2Nd Fl	2003	2,290		20	458	458	1,145	33
34	TOTAL (lines 1 thru 33)		\$ 6,147,338	\$ 119,298		\$ 37,515	\$ (81,783)	\$ 5,911,130	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 Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12B, Carried Forward		\$ 6,147,338	\$ 119,298		\$ 37,515	\$ (81,783)	\$ 5,911,130	1
2	Design L/Carpet Base 2Nd Last Pymnt	2003	1,588		20	318	318	794	2
3	Design L/Croner Guards 3Rd Fl (2)	2003	1,599		20	160	160	400	3
4	Design L/Renovation Wall/Ceiling 3Rd	2003	1,791		20	358	358	895	4
5	Design L/Renovation Wall/Ceiling 3Rd	2003	1,791		20	358	358	895	5
6	Design L/Wall Prep Covers 3Rd Fl	2003	2,289		20	458	458	1,145	6
7	Design L/Carpet Base 3Rd Flr	2003	1,586		20	317	317	793	7
8	Design L/Border Paper 2Nd Fl	2003	54		20	11	11	27	8
9	Design L/Sink & Counter/Cabinet	2003	1,704		20	114	114	284	9
10	Design L/Double Door For New Closet	2003	1,192		20	79	79	198	10
11	Xpert Fit/Wall Fixture Diffuser	2003	138		20	10	10	25	11
12	Design L/Door For 1St Flr	2003	55		20	4	4	9	12
13	Design Lines/3Rd Flr Corridor Prepar	2003	2,289		20	458	458	1,107	13
14	Design Lines/2Nd Flr Dining Rm Wall	2003	1,990		20	398	398	962	14
15	Design Lines/2Nd Flr Dining Room Ins	2003	1,890		20	189	189	457	15
16	Design Lines/2Nd Flr Dining Rm Crown	2003	610		20	61	61	147	16
17	Design Lines/2Nd Flr Dining Rm Remov	2003	432		20	29	29	70	17
18	Design Lines/3Rd Flr Work Surface/Si	2003	1,704		20	114	114	275	18
19	Design Lines/2Nd Flr Dining Room Con	2003	1,817		20	121	121	293	19
20	Design Lines/3Rd Flr Corridor Instal	2003	1,586		20	317	317	766	20
21	Design Lines/3Rd Flr Corridor Instal	2003	1,588		20	318	318	768	21
22	Design Lines/2Nd Flr Dining Room Wal	2003	1,990		20	398	398	962	22
23	Design Lines/Shipping Charges	2003	706		20	141	141	341	23
24	Design Lines/3Rd Flr Corridor Prepar	2003	2,290		20	458	458	1,107	24
25	Design Lines/3Rd Flr Demolition/Repa	2003	1,791		20	179	179	433	25
26	Design Lines/3Rd Flr Custom Worksurf	2003	1,704		20	114	114	275	26
27	Design L/Door Guard	2003	93		20	19	19	45	27
28	Design L/ Brich Doors Installation	2003	1,493		20	100	100	241	28
29	Design L/Relocate Springklers	2003	459		20	46	46	111	29
30	Design L/Vinyl Planks	2003	1,891		20	378	378	914	30
31	Design L/Borders/Wallcovering	2003	1,990		20	398	398	962	31
32	Design L/Custom Flr & Cabinet	2003	1,817		20	182	182	439	32
33	Design L/Crown Monlding & Installing	2003	610		20	61	61	147	33
34	TOTAL (lines 1 thru 33)		\$ 6,191,865	\$ 119,298		\$ 44,181	\$ (75,117)	\$ 5,927,417	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 Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12C, Carried Forward		\$ 6,191,865	\$ 119,298		\$ 44,181	\$ (75,117)	\$ 5,927,417	1
2	Design L/Flooring Dining	2003	2,160		20	432	432	1,008	2
3	Design L/Lower Level Flr Instal Vnl	2003	395		20	39	39	92	3
4	Design L/Crown Moulding & Install	2003	420		20	84	84	196	4
5	Design L/3Rd Flr Vinyl Plank	2003	1,890		20	378	378	882	5
6	Design L/Prep Of Walls/Instl/Borders	2003	1,991		20	398	398	929	6
7	Design L/Instl Vynil Plank	2003	1,893		20	379	379	884	7
8	Design L/3Rd Wallcovering/Borders	2003	1,990		20	398	398	929	8
9	Design L/2Nd Wallcovering/Borders	2003	2,038		20	408	408	951	9
10	Design L/3Rd Flr Revoval Of Cabinets	2003	432		20	43	43	101	10
11	Design L/3Rd Floor & Wall Cabinets	2003	1,817		20	182	182	424	11
12	Design L/2Nd Custom Flr/Wall Cabinet	2003	1,818		20	182	182	424	12
13	Design L/3Rd Flr Install Vynil Plank	2003	1,890		20	378	378	882	13
14	Design L/Lower Level Flr Border	2003	47		20	5	5	11	14
15	Design L/3Rd Flr Floor/Wall Cabinets	2003	1,817		20	182	182	424	15
16	Design L/3Rd Wallcover/Border	2003	1,991		20	398	398	896	16
17	Design L/3Rd Flr Vynil Plank	2003	1,893		20	379	379	852	17
18	Design L/3Rd Cons/Instl/Flr/Cabinet	2003	1,818		20	182	182	364	18
19	Design L/3Rd Corridor Carpet	2003	95		20	19	19	38	19
20	J J Urbika/Elevator Modernization	2003	1,452		20	145	145	290	20
21	Design L/2 Fl Counter Tops Dining Rm	2003	36		20	2	2	4	21
22	Div. Gralak/East Sidewalk Rep 50%	2003	816		20	54	54	108	22
23	Design L/East Room Vertical Blinds	2003	697		20	139	139	278	23
24	Medline/Wheelchair	2003	211		20	42	42	84	24
25	Otis/Renovation	2003	4,300		20	430	430	860	25
26	Murphy & Miller/Compressor	2003	1,582		20	105	105	202	26
27	Div. Gralak/East Sidewalk Rep Final	2003	816		20	54	54	99	27
28	Sing / Graphics Installed (Entrance)	2003	79		20	16	16	29	28
29	Urbikas & Asso/Elevator (Architects)	2003	548		20	55	55	96	29
30	Murphy & Miller/Ac Compressor	2003	1,984		20				30
31	Urbikas & Asso/Elevators (Architect)	2003	411		20	41	41	68	31
32	Countertop Svcs 50%Depst/1215 & 1002	2003	191		20	13	13	21	32
33	Bear Construcion/Entrance Door	2003	9,563		20	956	956	1,514	33
34	TOTAL (lines 1 thru 33)		\$ 6,240,946	\$ 119,298		\$ 50,700	\$ (68,598)	\$ 5,941,358	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12D, Carried Forward		\$ 6,240,946	\$ 119,298		\$ 50,700	\$ (68,598)	\$ 5,941,358	1
2	Murphy-Miller/Smoke Damper	2004	2,363		20	236	236	354	2
3	Rae Coating/Floor Abulance Entrance	2004	337		20	34	34	45	3
4	Rae Coating/Removal Flr Tiles & Prep	2004	674		20	67	67	89	4
5	Rea Coating/Flake Epoxi Coating	2004	208		20	21	21	28	5
6	Otis Elevators/Service Elevator	2004	28,667		20	2,867	2,867	3,584	6
7	Design L/Dept 1For Game Room	2004	653		20	131	131	164	7
8	Murphy & Miller/Steam Humidifier	2004	1,106		20	74	74	92	8
9	Ward Door/Door Instalation	2004	288		20	29	29	36	9
10	Design L 50%/Wallcover Game Room	2004	676		20	135	135	158	10
11	Edward Sys/Smoke Detector	2004	712		20	71	71	77	11
12	3Rd Elevator	2004	34,320		20	3,432	3,432	3,432	12
13	Final Payment Of Elevators	2004	1,351		20	135	135	135	13
14	Smoke Detectors & Relay Mod	2004	2,994		20	299	299	299	14
15	Sprinkler Pipe & New Heads	2004	555		20	37	37	37	15
16	Repaired Sprinkler Pipe	2004	635		20	42	42	42	16
17	Relief Valves On Chiller	2004	891		20	45	45	45	17
18	Pc Board & Sensor On Chiller	2004	555		20	28	28	28	18
19	Sidewalk From East Door	2005	1,140		20	114	114	114	19
20	Elevator	2005	1,280		20	128	128	128	20
21	Powermate Heating Valve	2005	485		20	24	24	24	21
22	Auto Condensate Drain On Air System	2005	1,025		20	51	51	51	22
23	Expansion Valve On A/C	2005	560		20	28	28	28	23
24	Boiler Pump Motor	2005	802		20	40	40	40	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12E, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12F, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12G, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12H, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12I, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place**

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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 12J, Carried Forward		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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)		\$ 6,323,222	\$ 119,298		\$ 58,768	\$ (60,530)	\$ 5,950,388	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 Place

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	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 Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Place

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	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 Place # 0037515 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	\$ 691,727	\$	\$ 57,412	\$ 57,412	10	\$ 435,761	71
72	Current Year Purchases	1,043		104	104	10	104	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 692,770	\$	\$ 57,516	\$ 57,516		\$ 435,865	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	1999 Plymouth Voyager	2004	\$ 1,382	\$	\$ 691	\$ 691	5	\$ 691	76
77	Facility Use	2005 Glaval Universal Bus	2004	12,922		2,584	2,584	5	2,584	77
78										78
79										79
80	TOTALS			\$ 14,304	\$	\$ 3,275	\$ 3,275		\$ 3,275	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)	\$ 7,921,721	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,298	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,559	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 261	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,389,528	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	Independent Living Alloc. - 2005	\$ 21,016,866	\$ 978,355	\$ 5,846,467	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 21,016,866	\$ 978,355	\$ 5,846,467	91

G. Construction-in-Progress

	Description	Cost	
92	C-I-P	\$ 1,976,863	92
93			93
94			94
95		\$ 1,976,863	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: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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?

YES NO

16. Rental Amount for movable equipment: \$ 15,688

Description: See Attached Schedule

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	39 - 03	hrs	\$		\$ 159,514	\$		\$ 159,514	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,104			10,104	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			195,416			195,416	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				94,413		94,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>						36,001		36,001	13
14	TOTAL			\$		\$ 365,034	\$ 130,414		\$ 495,448	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 Place# 0037515Report Period Beginning: 07/01/04

Ending:

06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/05

(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	\$ 248,213	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	400,428		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,011,481		5
6	Prepaid Insurance	205,283		6
7	Other Prepaid Expenses	66,043		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	53,060		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,984,508	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	22,084,463		14
15	Leasehold Improvements, at Historical Cost	1,208,211		15
16	Equipment, at Historical Cost	2,387,537		16
17	Accumulated Depreciation (book methods)	(12,235,743)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,280,053		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,029,441		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,007,574	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,992,082	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,031,735	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	139,864		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	180,822		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	4,373,246		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,725,667	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	19,516,640		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 19,516,640	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 28,242,307	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,250,225)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,992,082	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,153,688)	1
2	Restatements (describe):		2
3	Correction of prior year	(128,912)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,282,600)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	979,290	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) <u>Temporarily Restricted Net Assets</u>	53,085	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,032,375	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)	\$ (3,250,225)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 07/01/04Ending: 06/30/05**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	\$ 4,580,145	1
2	Discounts and Allowances for all Levels	(836,143)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,744,002	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	731,687	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 731,687	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	60,875	14
15	Telephone, Television and Radio	6,935	15
16	Rental of Facility Space	223,204	16
17	Sale of Drugs	108,766	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,538	19
20	Radiology and X-Ray	1,405	20
21	Other Medical Services	300,814	21
22	Laundry	18,244	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 731,781	23
D. Non-Operating Revenue			
24	Contributions	7,345	24
25	Interest and Other Investment Income***	78,567	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 85,912	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,838,956	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,838,956	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,132,338	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,727,646	31
32	Health Care	1,644,771	32
33	General Administration	2,459,103	33
B. Capital Expense			
34	Ownership	1,131,265	34
C. Ancillary Expense			
35	Special Cost Centers	2,139,345	35
36	Provider Participation Fee	50,918	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,153,048	40
41	Income before Income Taxes (line 30 minus line 40)**	979,290	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 979,290	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Place

0037515

Report Period Beginning:

07/01/04

Ending:

06/30/05

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	1,914	2,032	\$ 93,597	\$ 46.06	1
2	Assistant Director of Nursing	4,143	4,398			2
3	Registered Nurses	6,452	6,849	165,311	24.14	3
4	Licensed Practical Nurses	25,465	27,033	523,154	19.35	4
5	CNAs & Orderlies	58,924	62,552	576,317	9.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,096	31,299	14.93	9
10	Activity Assistants	4,930	5,234	48,251	9.22	10
11	Social Service Workers	1,890	2,006	19,563	9.75	11
12	Dietician	1,156	1,227	24,436	19.92	12
13	Food Service Supervisor	2,616	2,777	56,154	20.22	13
14	Head Cook	1,171	1,243	23,725	19.09	14
15	Cook Helpers/Assistants	31,875	33,837	277,464	8.20	15
16	Dishwashers					16
17	Maintenance Workers	8,260	8,769	127,675	14.56	17
18	Housekeepers	6,409	6,804	62,458	9.18	18
19	Laundry	3,945	4,188	37,703	9.00	19
20	Administrator	2,020	2,144	116,716	54.44	20
21	Assistant Administrator					21
22	Other Administrative	2,023	2,148	146,089	68.01	22
23	Office Manager					23
24	Clerical	7,177	7,619	72,150	9.47	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	2,038	2,164	29,589	13.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	11,141	11,826	205,505	17.38	33
34	TOTAL (lines 1 - 33)	185,524	196,946	\$ 2,637,156 *	\$ 13.39	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		\$ 2,146	01-03	35
36	Medical Director	monthly	29,928	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant		353	10-03	38
39	Pharmacist Consultant	monthly	1,100	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	monthly	2,110	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,637		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning: 07/01/04

Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Monica Ramirez	Administrator	0	\$ 116,716	Workers' Compensation Insurance	\$ 87,679	IDPH License Fee	\$	
Deborah Hart	CFO	0	134,231	Unemployment Compensation Insurance		Advertising: Employee Recruitment	13,906	
Michael Apa	Executive Director	0	161,137	FICA Taxes	201,739	Health Care Worker Background Check	1,262	
				Employee Health Insurance	192,461	(Indicate # of checks performed)		
Allocation to Independent Living			(149,279)	Employee Meals	45,169	Licenses / Permit Fees	11,092	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	18,210	
				Flex Benefits	332,414	Allocation to Independent Living	(22,476)	
TOTAL (agree to Schedule V, line 17, col. 1)				Life Insurance	1,382			
(List each licensed administrator separately.)			\$ 262,805	Health Spending Administration	1,437			
				401K Admin Expense	4,025	Less: Public Relations Expense	()	
B. Administrative - Other				Drug Testing	1,456	Non-allowable advertising	()	
Description			Amount	Employee Appreciation	11,670	Yellow page advertising	()	
			\$	See Supplemental Schedule	(128,011)			
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,994	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 751,421			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services								
Vendor/Payee	Type		Amount				G. Schedule of Travel and Seminar**	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 18,000				Description	
ADP	Payroll Processing		21,418				Amount	
PSD	IS Support Services		11,958				Out-of-State Travel	
See Attached	Legal		197,136				\$	
							In-State Travel	
							Seminar Expense	
							17,171	
							Allocation to Independent Living	
							(8,678)	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 248,512	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)							\$ 8,493	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes (Aides)
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,794 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. _____
- (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. \$ 50,918
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? Yes
- (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? Yes 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. \$ 45,169 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,634
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
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? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt, 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. _____
- (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