

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0039347

**Facility Name:** Mongomery Nursing & Rehabilitation Center

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

**County:** Montgomery

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

**HFS ID Number:** 37-1323740

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

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>J. Terry Dooling</u>	
	(Title) <u>Treasurer</u>	
<b>Paid Preparer</b>	(Signed) <u>See Accountants Compilation Report</u>	(Date) _____
	(Print Name and Title) <u>J. Terry Dooling Partner</u>	
	(Firm Name & Address) <u>C.J. Schlosser &amp; Company, L.L.C. 233 East Center Drive, Alton, IL 62002</u>	
	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center

# 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>21</u>	Skilled (SNF)	<u>21</u>	<u>7,665</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>80</u>	Intermediate (ICF)	<u>80</u>	<u>29,200</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,094</u>	<u>2,600</u>	<u>4,386</u>	<u>10,080</u>	8
9	SNF/PED					9
10	ICF	<u>11,788</u>	<u>9,904</u>		<u>21,692</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,882</u>	<u>12,504</u>	<u>4,386</u>	<u>31,772</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.18%

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)

Daycare

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 04/01/1994

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

YES  Date 04/01/1994 NO

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

YES  NO  If YES, enter number of beds certified 20 and days of care provided 4,386

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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	
	<b>A. General Services</b>											
1	Dietary	193,010	14,759	5,731	213,500		213,500		213,500			1
2	Food Purchase		157,682		157,682		157,682		157,682			2
3	Housekeeping	97,514	13,721		111,235		111,235		111,235			3
4	Laundry	66,557	14,928		81,485		81,485		81,485			4
5	Heat and Other Utilities			96,432	96,432		96,432	513	96,945			5
6	Maintenance	46,678	6,855	43,596	97,129	1,027	98,156	564	98,720			6
7	Other (specify):* <b>Waste Removal</b>			6,799	6,799		6,799		6,799			7
8	<b>TOTAL General Services</b>	<b>403,759</b>	<b>207,945</b>	<b>152,558</b>	<b>764,262</b>	<b>1,027</b>	<b>765,289</b>	<b>1,077</b>	<b>766,366</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,183,957	75,082	27,975	1,287,014	(7,200)	1,279,814		1,279,814			10
10a	Therapy		1,396	273,867	275,263		275,263	3,663	278,926			10a
11	Activities	59,895	2,857	548	63,300	365	63,665		63,665			11
12	Social Services	31,611	25	548	32,184		32,184		32,184			12
13	CNA Training					10,269	10,269		10,269			13
14	Program Transportation		4,033		4,033		4,033		4,033			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,275,463</b>	<b>83,393</b>	<b>312,538</b>	<b>1,671,394</b>	<b>3,434</b>	<b>1,674,828</b>	<b>3,663</b>	<b>1,678,491</b>			16
	<b>C. General Administration</b>											
17	Administrative	65,812	8,929	196,284	271,025	(2,373)	268,652	(94,705)	173,947			17
18	Directors Fees			60,000	60,000		60,000	(60,000)				18
19	Professional Services			47,382	47,382	981	48,363	(38,180)	10,183			19
20	Dues, Fees, Subscriptions & Promotions			59,443	59,443	(1,250)	58,193	(30,998)	27,195			20
21	Clerical & General Office Expenses	55,242	16,634	54,179	126,055		126,055	20,810	146,865			21
22	Employee Benefits & Payroll Taxes			268,167	268,167		268,167	9,653	277,820			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,362	14,362	(1,819)	12,543	4,492	17,035			24
25	Other Admin. Staff Transportation							1,222	1,222			25
26	Insurance-Prop.Liab.Malpractice			48,104	48,104		48,104	1,847	49,951			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	<b>121,054</b>	<b>25,563</b>	<b>747,921</b>	<b>894,538</b>	<b>(4,461)</b>	<b>890,077</b>	<b>(185,859)</b>	<b>704,218</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,800,276</b>	<b>316,901</b>	<b>1,213,017</b>	<b>3,330,194</b>		<b>3,330,194</b>	<b>(181,119)</b>	<b>3,149,075</b>			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 Mongomery Nursing & Rehabilitation Center #0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			101,095	101,095	101,095	3,222	104,317			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			408,426	408,426	408,426	(25,172)	383,254			32
33	Real Estate Taxes			44,644	44,644	44,644	759	45,403			33
34	Rent-Facility & Grounds						3,296	3,296			34
35	Rent-Equipment & Vehicles			1,104	1,104	1,104		1,104			35
36	Other (specify):* <b>Mortgage Ins.</b>			11,551	11,551	11,551		11,551			36
37	<b>TOTAL Ownership</b>			566,820	566,820	566,820	(17,895)	548,925			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			12	12	12		12			38
39	Ancillary Service Centers		136,850	18,239	155,089	155,089		155,089			39
40	Barber and Beauty Shops		1,080		1,080	1,080		1,080			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			55,298	55,298	55,298		55,298			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		137,930	73,549	211,479	211,479		211,479			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,800,276	454,831	1,853,386	4,108,493	4,108,493	(199,014)	3,909,479			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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(517)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,506)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,428)	20		18
19	Entertainment	(3,491)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,985)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,689)	20		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (36,616)		\$	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)	(162,398)	Var.	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (162,398)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (199,014)		37

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

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

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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Mongomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Eliminate PAC & Lobbying Dues	\$ (2,194)	20	1
2	Eliminate expense for 2007 IDPH license paid in 2006	(1,990)	20	2
3	Add expense for 2006 IDPH license paid in 2005	995	20	3
4	Eliminate expense for 2005 CNA exams paid in 2006	(500)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(3,689)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2006

Ending:

12/31/2006**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	513	0	0	0	0	0	0	0	0	0	513	5
6	Maintenance	0	564	0	0	0	0	0	0	0	0	0	564	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	1,077	0	0	0	0	0	0	0	0	0	1,077	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	3,663	0	0	0	0	0	0	0	0	3,663	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	3,663	0	0	0	0	0	0	0	0	3,663	16
	<b>C. General Administration</b>													
17	Administrative	0	34,376	(129,081)	0	0	0	0	0	0	0	0	(94,705)	17
18	Directors Fees	0	0	(60,000)	0	0	0	0	0	0	0	0	(60,000)	18
19	Professional Services	0	2,005	(40,185)	0	0	0	0	0	0	0	0	(38,180)	19
20	Fees, Subscriptions & Promotions	(32,608)	1,610	0	0	0	0	0	0	0	0	0	(30,998)	20
21	Clerical & General Office Expenses	0	20,810	0	0	0	0	0	0	0	0	0	20,810	21
22	Employee Benefits & Payroll Taxes	0	9,653	0	0	0	0	0	0	0	0	0	9,653	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,491)	7,983	0	0	0	0	0	0	0	0	0	4,492	24
25	Other Admin. Staff Transportation	0	1,222	0	0	0	0	0	0	0	0	0	1,222	25
26	Insurance-Prop.Liab.Malpractice	0	1,847	0	0	0	0	0	0	0	0	0	1,847	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(36,099)	79,506	(229,266)	0	0	0	0	0	0	0	0	(185,859)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(36,099)	80,583	(225,603)	0	0	0	0	0	0	0	0	(181,119)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	3,222	0	0	0	0	0	0	0	0	0	3,222	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(517)	0	(24,655)	0	0	0	0	0	0	0	0	(25,172)	32
33	Real Estate Taxes	0	759	0	0	0	0	0	0	0	0	0	759	33
34	Rent-Facility & Grounds	0	3,296	0	0	0	0	0	0	0	0	0	3,296	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(517)</b>	<b>7,277</b>	<b>(24,655)</b>	<b>0</b>	<b>(17,895)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(36,616)</b>	<b>87,860</b>	<b>(250,258)</b>	<b>0</b>	<b>(199,014)</b>	<b>45</b>							

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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)		
1	V	5 See Schedule VIII	\$	Wellington Management Co.	60.00%	\$ 513	\$ 513	1	
2	V	6 See Schedule VIII		Wellington Management Co.	60.00%	564	564	2	
3	V	17 See Schedule VIII		Wellington Management Co.	60.00%	34,376	34,376	3	
4	V	19 See Schedule VIII		Wellington Management Co.	60.00%	2,005	2,005	4	
5	V	20 See Schedule VIII		Wellington Management Co.	60.00%	1,610	1,610	5	
6	V	21 See Schedule VIII		Wellington Management Co.	60.00%	20,810	20,810	6	
7	V	22 See Schedule VIII		Wellington Management Co.	60.00%	9,653	9,653	7	
8	V	24 See Schedule VIII		Wellington Management Co.	60.00%	7,983	7,983	8	
9	V	25 See Schedule VIII		Wellington Management Co.	60.00%	1,222	1,222	9	
10	V	26 See Schedule VIII		Wellington Management Co.	60.00%	1,847	1,847	10	
11	V	30 See Schedule VIII		Wellington Management Co.	60.00%	3,222	3,222	11	
12	V	33 See Schedule VIII		Wellington Management Co.	60.00%	759	759	12	
13	V	34 See Schedule VIII		Wellington Management Co.	60.00%	3,296	3,296	13	
14	Total		\$			\$ 87,860	\$ *	87,860	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	10	Nursing and Medical Records	\$ 26,079	Wellington Management Co.	60.00%	\$ 26,079	\$	15
16	V	17	Management Fees	141,324	Wellington Management Co.	60.00%		(141,324)	16
17	V	17	Management Fees	54,960	Health Care Financial, L.L.C.	40.00%	67,203	12,243	17
18	V	19	Professional Services	40,185	C.J. Schlosser & Company, L.L.C.	40.00%		(40,185)	18
19	V	10a	Therapy Services	273,867	NW Rehab, L.L.C.	100.00%	277,530	3,663	19
20	V	32	Interest	17,055	John H. Rothert	60.00%		(17,055)	20
21	V	32	Interest	3,800	J. Terry Dooling	15.00%		(3,800)	21
22	V	32	Interest	3,800	David L. Kamler	15.00%		(3,800)	22
23	V	18	Director's Fees	36,000	John H. Rothert	60.00%		(36,000)	23
24	V	18	Director's Fees	12,000	J. Terry Dooling	15.00%		(12,000)	24
25	V	18	Director's Fees	12,000	David L. Kamler	15.00%		(12,000)	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		\$ 621,070				\$ 370,812	\$ * (250,258)	39

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

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	145,899	7.58	18.95	Salary	\$ 34,101	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 34,101		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 Mongomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning: 01/01/2006

Ending: 2/31/2006

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs 18,906,420	5	\$ 2,708	\$	3,581,847	\$ 513	1
2	6	Maintenance	Accumulated Costs 18,906,420	5	2,977		3,581,847	564	2
3	17	Administrative	Accumulated Costs 18,906,420	5	181,451	181,451	3,581,847	34,376	3
4	19	Professional Services	Accumulated Costs 18,906,420	5	10,584		3,581,847	2,005	4
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs 18,906,420	5	8,500		3,581,847	1,610	5
6	21	Clerical and General Office Exp.	Accumulated Costs 18,906,420	5	109,841	109,841	3,581,847	20,810	6
7	22	Employee Benefits and R Taxes	Accumulated Costs 18,906,420	5	50,950		3,581,847	9,653	7
8	24	Travel and Seminar	Accumulated Costs 18,906,420	5	42,140		3,581,847	7,983	8
9	25	Other Admin Staff Transport	Accumulated Costs 18,906,420	5	6,451		3,581,847	1,222	9
10	26	Insurance - Prop, Liab, Malprac.	Accumulated Costs 18,906,420	5	9,751		3,581,847	1,847	10
11	30	Depreciation	Accumulated Costs 18,906,420	5	17,006		3,581,847	3,222	11
12	33	Real Estate Taxes	Accumulated Costs 18,906,420	5	4,008		3,581,847	759	12
13	34	Rent-Facility and Ground	Accumulated Costs 18,906,420	5	17,395		3,581,847	3,296	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				\$ 463,762	\$ 291,292		\$ 87,860	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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	GMAC Commercial Mortgage		X	Refinance Mortgage	\$17,016.17	9/29/99	\$ 2,415,500	\$	10/1/34	7.9200	\$ 236,362	1						
2	Ford Credit		X	Van Loan	\$596.16	3/15/04	33,260	15,005	3/14/09	2.9000	539	2						
3	Capmark Finance, Inc.		X	Refinance Mortgage	\$13,209.94	11/30/06	2,415,500	2,413,663	11/30/41	5.6500	11,258	3						
4									Loan Cost Amortization		134,195	4						
5									Interest Income		(517)	5						
<b>Working Capital</b>																		
6	Health Care Financial	X		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.5000		6						
7	First National Bank		X	Line of Credit	N/A	1/4/05	100,000		1/4/06	prime+1%		7						
8	First National Bank		X	Line of Credit	N/A	5/17/06	250,000	1	5/17/07	prime+1%	1,417	8						
9	<b>TOTAL Facility Related</b>				\$30,822.27		\$ 5,294,260	\$ 2,508,669			\$ 383,254	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,294,260	\$ 2,508,669			\$ 383,254	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,551 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Montgomery Nursing & Rehabilitation Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-100-716-75</u>	<u>NE PT SE SW Land Corp Limit</u>	\$ <u>40,644.48</u>	\$ <u>40,644.48</u>
2. _____	<u>Taylor Springs</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,644.48</u>	\$ <u>40,644.48</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center# 0039347 Report Period Beginning:01/01/2006 Ending:12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	101	1994		\$ 962,086	\$ 38,484	25	\$ 38,484	\$	\$ 490,664	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Shed	1994		3,247		10			3,247	9
10	Air Conditioner	1994		76,140		10			76,140	10
11	Cabinets	1994		6,809	340	20	340		4,170	11
12	Doors	1994		2,337	117	20	117		1,441	12
13	Electrical	1994		4,601	230	20	230		2,794	13
14	Flooring	1994		25,850		10			25,850	14
15	Exterior Remodeling	1994		4,468	298	15	298		3,674	15
16	Interior Remodeling	1994		66,214	4,386	15	4,386		53,746	16
17	Nurse Call System	1994		1,960	131	15	131		1,601	17
18	Plumbing	1994		6,619	331	20	331		4,046	18
19	Roof	1994		29,619		10			29,619	19
20	Windows/Gutter	1994		60,254	4,017	15	4,017		49,877	20
21	Siding	1994		15,818	1,055	15	1,055		12,729	21
22	Landscaping	1994		3,134		10			3,134	22
23	Parking Lot	1994		29,107		10			29,107	23
24	Home Office Wallpapering/Flooring	1994		2,996		5			2,994	24
25	Flooring	1995		938		10			938	25
26	Metal Doors and Frames	1996		953	48	20	48		501	26
27	Metal Carport	1997		972	65	15	65		600	27
28	Carpet	1997		2,310		5			2,310	28
29	Dining Room Chair Rail	1997		2,230	149	15	149		1,338	29
30	Wallpapering	1997		4,830		5			4,830	30
31	Fire Doors	1997		593	30	20	30		267	31
32	Foliage & Fountains	1997		1,657	166	10	166		1,616	32
33	Interior Painting	1997		514		5			514	33
34	Shed	1997		315	32	10	32		287	34
35	Door Alarm System	1997		7,840	784	10	784		7,122	35
36	Sidewalk Replacement	1997		650	43	15	43		393	36

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

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

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Beauty Shop Remodeling	1998	\$ 4,287	\$ 214	20	\$ 214	\$	\$ 1,768	37
38	Wallpapering	1998	1,493		5			1,493	38
39	Shower Room Remodeling	1998	1,199	60	20	60		500	39
40	Mini Blinds Installed	1998	509	51	10	51		453	40
41	Shelving	1998	566	28	20	28		238	41
42	Baseboard Remodeling	1998	820	82	10	82		731	42
43	Water Heater	1998	6,040	403	15	403		3,322	43
44	Folding Doors	1998	456	46	10	46		376	44
45	Door Installed	1998	208	21	10	21		170	45
46	Wall Mounted Laundry Tub	1998	181	9	20	9		81	46
47	Shower Flooring	1998	401	40	10	40		324	47
48	Shed	1998	185	19	10	19		150	48
49	Flooring	1998	293	29	10	29		246	49
50	Air Conditioning Unit	2000	557	56	10	56		367	50
51	Asphalt Parking Lot	2000	2,360	236	10	236		1,495	51
52	Fire Doors	2001	1,534	102	15	102		571	52
53	Signage	2001	3,318	277	5	277		3,318	53
54	Cove Base	2001	1,006	101	10	101		560	54
55	Window Treatments	2001	7,272	606	5	606		7,272	55
56	Wallpapering	2001	37,693	3,189	5	3,189		37,693	56
57	Lobby Carpet	2001	1,433	96	5	96		1,433	57
58	Air Conditioning Unit	2001	1,696	170	10	170		933	58
59	Home Office Wallpapering	1999	504		5			504	59
60	Cove Base	2002	604	60	10	60		251	60
61	Wallpapering	2002	4,462	892	5	892		4,231	61
62	Air Conditioning Unit	2002	1,981	198	10	198		925	62
63	Blinds	2002	512	102	5	102		503	63
64	Flooring & Cove Base	2002	1,630	163	10	163		801	64
65	Wall Guard	2002	1,927	128	15	128		620	65
66	Fire Doors	2002	1,042	69	15	69		312	66
67	A/C/Heat Pump Units	2002	1,580	158	10	158		698	67
68	Home Office Light Fixtures	2002	182		10	18	18	90	68
69	Air Conditioning Unit	2003	3,110	311	10	311		1,051	69
70	TOTAL (lines 4 thru 69)		\$ 1,416,102	\$ 58,622		\$ 58,640	\$ 18	\$ 889,029	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,416,102	\$ 58,622		\$ 58,640	\$ 18	\$ 889,029	1
2	11 Firw Doors	2003	5,950	397	15	397		1,289	2
3	Home Office Cabinets	2003	791		10	79	79	277	3
4	Closet Doors-Resident Rooms	2004	3,628	242	15	242		607	4
5	Wiring Outside Lights	2004	1,145	57	10	57		167	5
6	Tile	2004	878	88	10	88		256	6
7	Commercial Water Heater	2004	7,664	766	10	766		1,916	7
8	Floor Tile	2004	1,186	119	10	119		248	8
9	66 Gallon Water Heater	2004	931	93	10	93		194	9
10	Patio & Sidewalks	2004	14,316	954	15	954		2,227	10
11	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		253	11
12	Gravel Parking Lot	2004	3,355	671	5	671		1,845	12
13	Range Hood	2005	831	41	20	41		83	13
14	Closet Doors-Resident Rooms	2005	3,689	369	10	369		655	14
15	Outside Light Fixtures	2005	2,025	202	10	202		347	15
16	Air Conditioning Unit	2005	7,609	761	10	761		1,112	16
17	Generator Wiring	2005	1,660	332	5	332		498	17
18	Electrical Work	2005	5,528	276	20	276		415	18
19	Tile & Cove Base	2005	2,064	205	10	205		292	19
20	Heating/Cooling Unit	2005	558	111	5	111		157	20
21	Wallpaper	2005	810	162	5	162		202	21
22	Therapy Room Cabinets	2005	1,200	80	15	80		80	22
23	New Roof-200 & 500 Wings	2005	74,745	4,983	15	4,983		6,229	23
24	Wall Guard	2006	570	32	15	32		32	24
25	6 Oak Doors	2006	3,469	135	15	135		135	25
26	Smoke Detectors	2006	683	45	10	45		45	26
27	Exhaust Fans for Kitchen	2006	1,035	26	10	26		26	27
28	New Roof-300 Wing	2006	15,100		15				28
29	Shower & Wall Remodel	2006	5,510		20				29
30	Water Heaters	2006	1,696	93	10	93		93	30
31	Air Conditioning Unit	2006	3,413	279	10	279		279	31
32	Storage Shed	2006	1,582	86	10	86		86	32
33	Fire Doors	2006	4,939	55	15	55		55	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,596,182	\$ 70,383		\$ 70,480	\$ 97	\$ 909,129	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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		\$ 1,596,182	\$ 70,383		\$ 70,480	\$ 97	\$ 909,129	1
2	Patio and Sidewalks	2006	9,566	323	15	323		323	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,605,748	\$ 70,706		\$ 70,803	\$ 97	\$ 909,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

## 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	\$ 190,685	\$ 20,007	\$ 21,076	\$ 1,069	5-20	\$ 106,435	71
72	Current Year Purchases	24,935	817	826	9	5-15	826	72
73	Fully Depreciated Assets	315,139	616	616		5-10	315,139	73
74								74
75	TOTALS	\$ 530,759	\$ 21,440	\$ 22,518	\$ 1,078		\$ 422,400	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2004 Ford Wheelchair Van	2004	\$ 35,799	\$ 8,950	\$ 8,950		4	\$ 25,358	76
77	Home Office - Admin	2000 Ford Taurus	2004	4,512				4	4,512	77
78	Home Office - Admin	1998 Jaguar	2004	4,258		1,064	1,064	4	2,661	78
79	See Schedule Attached			7,113		982	982	4	2,353	79
80	TOTALS			\$ 51,682	\$ 8,950	\$ 10,996	\$ 2,046		\$ 34,884	80

## E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,215,862	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,317	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,221	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,366,736	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Section Not Applicable

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

N/A YES  N/A NO

16. Rental Amount for movable equipment: \$ 697 Description: Ice Machines \$292; Propane \$369; Gas Tank \$36

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		839		839
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,200		7,200
6	Transportation				
7	Contractual Payments		420		420
8	CNA Competency Tests		1,810		1,810
9	TOTALS	\$	\$ 10,269	\$	\$ 10,269
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,269		

**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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>25</b>

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,8	3327 hrs	\$ 100,127		\$	\$	3,327	\$ 100,127	1
2	Licensed Speech and Language Development Therapist	10a,8	1713 hrs	75,388				1,713	75,388	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	3185 hrs	102,015			1,396	3,185	103,411	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				136,850		136,850	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees	39,3				12,392				
	Other (specify): X-Rays	39,3				5,847			5,847	13
14	TOTAL			\$ 277,530		\$ 18,239	\$ 138,246	8,225	\$ 421,623	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 70,536	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>36,982</u> )	796,408		3
4	Supply Inventory (priced at )	13,120		4
5	Short-Term Investments			5
6	Prepaid Insurance	40,511		6
7	Other Prepaid Expenses	3,749		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 924,324	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	91,682		13
14	Buildings, at Historical Cost	1,537,268		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	553,094		16
17	Accumulated Depreciation (book methods)	(1,342,363)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	93,587		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	48,588		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,002,056	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,926,380	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 680,587	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,780		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,562		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Parties</u>	387,850		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,250,779	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	207,798		39
40	Mortgage Payable	2,461,858		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,669,656	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,920,435	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,994,055)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,926,380	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,735,207)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,735,207)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(258,848)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (258,848)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (1,994,055)</b>	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 01/01/2006Ending: 12/31/2006**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,722,043	1
2	Discounts and Allowances for all Levels	(367,354)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,354,689</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care	1,677	4
5	Other Care for Outpatients		5
6	Therapy	462,830	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 464,507</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	6,680	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,599	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 17,279</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	230	24
25	Interest and Other Investment Income***	9,236	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 9,466</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	3,704	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,704</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,849,645</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	764,262	31
32	Health Care	1,671,394	32
33	General Administration	894,538	33
<b>B. Capital Expense</b>			
34	Ownership	566,820	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	156,181	35
36	Provider Participation Fee	55,298	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,108,493</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(258,848)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (258,848)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See attached If not, please attach a reconciliation.

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

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,028	2,028	\$ 50,235	\$ 24.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,671	8,831	172,043	19.48	3
4	Licensed Practical Nurses	17,431	18,402	293,809	15.97	4
5	CNAs & Orderlies	72,693	75,756	635,004	8.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,545	6,052	59,895	9.90	10
11	Social Service Workers	1,860	2,186	31,611	14.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,205	23,788	193,010	8.11	15
16	Dishwashers					16
17	Maintenance Workers	3,877	4,065	46,678	11.48	17
18	Housekeepers	11,482	12,537	97,513	7.78	18
19	Laundry	9,382	9,872	66,557	6.74	19
20	Administrator	2,080	2,080	65,813	31.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,882	4,374	55,242	12.63	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	2,291	2,475	32,866	13.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,427	172,446	\$ 1,800,276 *	\$ 10.44	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	114	\$ 5,731	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	16	848	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,048	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	548	11,3	44
45	Social Service Consultant	8	548	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	26,079	10,3	47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 44,402		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mongomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	
Carla Vonder Harr	Administrator	0.00	\$ 65,812	Workers' Compensation Insurance	\$ 60,296	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	29,239	Advertising: Employee Recruitment	9,513	
				FICA Taxes	135,493	Health Care Worker Background Check		
				Employee Health Insurance	32,210	(Indicate # of checks performed <u>145</u> )	2,320	
				Employee Meals		Dues, Subscriptions, & Manuals	4,783	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	(235)	
				Staff Relations	8,621	Bank Service Charge	2,263	
				Employee Dental/Vision Insurance	1,229	IHCA Dues	3,866	
				Home Office Employee Benefits	9,653	Home Office Dues, Fees, Subscriptions	1,610	
				Employee Life/Disability Insurance	1,079	Resident Background Checks	2,080	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 65,812	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 27,195
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Wellington Management Co.- Management Fees				Section N/A			Out-of-State Travel	
\$ 141,324							\$	
Health Care Financial, L.L.C. - Management Fees							In-State Travel	
54,960							5,710	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 196,284				\$			3,342	
							Home Office Travel & Seminar	
							7,983	
							Entertainment Expense	
							( )	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	
\$ 47,382							\$ 17,035	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Healthcar Association \$3,866
- (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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,005 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,298  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 21.12%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Hughes & Associates, CPA, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

**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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

MONTGOMERY NURSING & REHABILITATION CENTER, INC.  
RECLASSES  
ATTACHMENT TO SCHEDULE V  
12/31/06

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(1,250)
NURSE AIDE TRAINING	13	1,250
To reclass expenses for CNA class books & test fees to proper line		
ADMINISTRATIVE	17	(2,373)
MAINTENANCE	6	1,027
ACTIVITIES	11	365
PROFESSIONAL SERVICES	19	981
To reclass maintenance supplies, activities supplies, & professional services to proper lines		
NURSE AIDE TRAINING	13	1,819
TRAVEL & SEMINAR	24	(1,819)
To reclass CNA class evaluator, books, & test fees to proper line		
NURSE AIDE TRAINING	13	7,200
NURSING & MEDICAL RECORDS	10	(7,200)
To reclass CNA trainer wages		

MONTGOMERY NURSING & REHABILITATION CENTER, INC.  
MISCELLANEOUS INCOME  
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28  
12/31/06

Miscellaneous Income	19
Gain on Insurance Stock Buyout	2,525
Seniorcise Program	<u>1,160</u>
	<u><u>3,704</u></u>

MONTGOMERY NURSING & REHABILITATION CENTER, INC.  
 TRAVEL AND SEMINAR SCHEDULE  
 ATTACHMENT TO SCHEDULE XIX PART G  
 12/31/2006

<u>SEMINAR PARTICIPANT</u>	<u>JOB TITLE</u>	<u>DATE(S)</u>	<u>CITY</u>	<u>TITLE OF SEMINAR</u>	<u>SPONSOR</u>	<u>COST</u>	<u>SEMINAR LODGING/ TRAVEL/MEALS</u>
Birdie Scroggins & Ginny Turner	Activities Supervisor & Assistant	10/25-10/27/06	Rock Island, IL	Get on Board & Get It Done	Illinois Activity Professionals Association	390	75
Amy Eliik	Corporate Accountant	5/31/2006	Alton, IL	Census & Billing/ Medicare B Caps	Compudata Health Corporation	27	
Various	Various	7/19/2006	Hillsboro, IL	IV Class	Enloe Drugs, Inc.	150	
Amy Eliik	Corporate Accountant	1/12/2006	Alton, IL	RUGs 53: Navigating the new payment categories from the SNF PPS Final Rule	hcPro	62	
Various	Various	9/11-9/14/06	Springfield, IL	IHCA Annual Convention & Trade Show	Illinois Healthcare Association	373	
Wendy Riggs	RN	10/19/2006	Springfield, IL	Basic Rehabilitation/Restorative Nursing	Lincoln Land Community College	430	115
Mindy Pearse & Lesley Brown	MAS/Care Plans & Business Office Manager	2/22/2006	Decatur, IL	Medicare Basics & RUGs 53	Illinois Healthcare Association	170	
Carla Vander Haar & Ramona Tamazzoli	Administrator & DON	5/25/2006	Springfield, IL	Alzheimer Disease & Related Disorders	SIUC School of Medicine & Alzheimer Association	100	
Carla Vander Haar & Ramona Tamazzoli	Administrator & DON	11/14-11/15/06	Springfield, IL	2006 Annual Convention & Trade Show	Illinois Nursing Home Administrators Association	250	
Lesley Brown & Jen Weiss	Business Office Manager & Administrative Asst.	2/15-2/16/06	Springfield, IL	Payroll Management	National Seminars	798	
						2,750	190
					Total Seminar Lodging/Travel/Meals	190	
					CPR Training	402	
					Other Travel Expense <\$250	5,710	
					Home Office Travel & Seminar	7,983	
					Total Travel & Seminar, Line 24	17,035	

**Montgomery Nursing & Rehabilitation Center**  
**Attachment to Sch. XI, Part D**  
**December 31, 2006**

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make &amp; Year</u>	<u>Year</u> <u>Acquired</u>	<u>Cost</u>	<u>Current Book</u> <u>Depreciation</u>	<u>Straight Line</u> <u>Depreciation</u>	<u>Adjustments</u>	<u>Life in</u> <u>Years</u>	<u>Accumulated</u> <u>Depreciation</u>
2001 Infiniti	2004	2,490	0	623	623	4	1,816
2000 Dodge Caravan	2005	947	0	237	237	4	414
2004 Infiniti	2006	3676	0	123	213	4	123
		<u>7,113</u>	<u>0</u>	<u>983</u>	<u>1,073</u>		<u>2,353</u>

**Montgomery Nursing & Rehabilitation Center**  
**Attachment to Sch. XVII**  
**December 31, 2006**

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	(258,848)
DEPRECIATION ADJUSTMENT	44,482
MISC. NON-DEDUCTIBLE EXPENSES	8,215
CONVERSION TO CASH BASIS ADJUSTMENTS	(17,480)
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>(223,631)</u></u>