

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	3,087	3,171	2,905	9,163	8	
9	SNF/PED					9	
10	ICF	11,761	12,082		23,843	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	14,848	15,253	2,905	33,006	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.53%

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 2,905

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	199,035	14,390	5,546	218,971		218,971	(900)	218,071		1
2	Food Purchase		155,214		155,214		155,214		155,214		2
3	Housekeeping	111,188	14,650		125,838		125,838		125,838		3
4	Laundry	71,427	13,692		85,119		85,119		85,119		4
5	Heat and Other Utilities			112,793	112,793		112,793	49	112,842		5
6	Maintenance	35,881	9,099	50,426	95,406	1,910	97,316	406	97,722		6
7	Other (specify):* Waste Removal			8,137	8,137		8,137		8,137		7
8	TOTAL General Services	417,531	207,045	176,902	801,478	1,910	803,388	(445)	802,943		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,242,055	73,200	25,718	1,340,973	(7,200)	1,333,773	(500)	1,333,273		10
10a	Therapy	6,857	3,362	376,087	386,306		386,306	(17,822)	368,484		10a
11	Activities	59,807	4,720	521	65,048	281	65,329		65,329		11
12	Social Services	31,680	317	521	32,518		32,518		32,518		12
13	CNA Training			1,343	1,343	7,560	8,903		8,903		13
14	Program Transportation		5,104		5,104		5,104		5,104		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,340,399	86,703	413,790	1,840,892	641	1,841,533	(18,322)	1,823,211		16
	C. General Administration										
17	Administrative	69,375	6,509	206,004	281,888	(2,658)	279,230	(121,162)	158,068		17
18	Directors Fees			30,000	30,000		30,000	(30,000)			18
19	Professional Services			49,701	49,701	447	50,148	(42,190)	7,958		19
20	Dues, Fees, Subscriptions & Promotions			58,750	58,750	(280)	58,470	(33,278)	25,192		20
21	Clerical & General Office Expenses	65,435	15,091	51,401	131,927		131,927	21,006	152,933		21
22	Employee Benefits & Payroll Taxes			302,542	302,542		302,542	8,125	310,667		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,739	8,739	(60)	8,679	614	9,293		24
25	Other Admin. Staff Transportation							1,425	1,425		25
26	Insurance-Prop.Liab.Malpractice			46,698	46,698		46,698	(6,543)	40,155		26
27	Other (specify):*										27
28	TOTAL General Administration	134,810	21,600	753,835	910,245	(2,551)	907,694	(202,003)	705,691		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,892,740	315,348	1,344,527	3,552,615		3,552,615	(220,770)	3,331,845		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			102,953	102,953		102,953	3,613	106,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			160,797	160,797		160,797	(30,607)	130,190			32
33	Real Estate Taxes			39,988	39,988		39,988		39,988			33
34	Rent-Facility & Grounds							7,229	7,229			34
35	Rent-Equipment & Vehicles			1,608	1,608		1,608		1,608			35
36	Other (specify):* Mortgage Ins.			12,069	12,069		12,069		12,069			36
37	TOTAL Ownership			317,415	317,415		317,415	(19,765)	297,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			4,476	4,476		4,476		4,476			38
39	Ancillary Service Centers		113,881	28,270	142,151		142,151		142,151			39
40	Barber and Beauty Shops		1,259		1,259		1,259		1,259			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,298	55,298		55,298		55,298			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		115,140	88,044	203,184		203,184		203,184			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,892,740	430,488	1,749,986	4,073,214		4,073,214	(240,535)	3,832,679			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	BHF 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	(6,090)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,787)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,469)	24		19
20	Contributions	(1,380)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,077)	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	(11,790)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,593)		\$	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)	(185,942)	Var.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (185,942)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (240,535)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Reimbursement from state for vocational rehab	\$ (900)	1	1
2	Reimbursement from employee for training	(955)	24	2
3	Bonus repaid by Certified NA	(500)	10	3
4	Eliminate PAC & Lobbying Dues	(2,119)	20	4
5	Add expense for 2007 IDPH license paid in 2006	995	20	5
6	Offset liability insurance dividend received	(8,311)	26	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,790)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(900)	0	0	0	0	0	0	0	0	0	0	(900)	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	49	0	0	0	0	0	0	0	0	0	49	5
6	Maintenance	0	406	0	0	0	0	0	0	0	0	0	406	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(900)	455	0	0	0	0	0	0	0	0	0	(445)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(500)	0	0	0	0	0	0	0	0	0	0	(500)	10
10a	Therapy	0	0	(17,822)	0	0	0	0	0	0	0	0	(17,822)	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	TOTAL Health Care and Programs	(500)	0	(17,822)	0	(18,322)	16							
	C. General Administration													
17	Administrative	0	26,580	(147,742)	0	0	0	0	0	0	0	0	(121,162)	17
18	Directors Fees	0	0	(30,000)	0	0	0	0	0	0	0	0	(30,000)	18
19	Professional Services	0	297	(42,487)	0	0	0	0	0	0	0	0	(42,190)	19
20	Fees, Subscriptions & Promotions	(35,368)	2,090	0	0	0	0	0	0	0	0	0	(33,278)	20
21	Clerical & General Office Expenses	0	21,006	0	0	0	0	0	0	0	0	0	21,006	21
22	Employee Benefits & Payroll Taxes	0	8,125	0	0	0	0	0	0	0	0	0	8,125	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,424)	4,038	0	0	0	0	0	0	0	0	0	614	24
25	Other Admin. Staff Transportation	0	1,425	0	0	0	0	0	0	0	0	0	1,425	25
26	Insurance-Prop.Liab.Malpractice	(8,311)	1,768	0	0	0	0	0	0	0	0	0	(6,543)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(47,103)	65,329	(220,229)	0	(202,003)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,503)	65,784	(238,051)	0	(220,770)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	3,613	0	0	0	0	0	0	0	0	0	3,613	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,090)	138	(24,655)	0	0	0	0	0	0	0	0	(30,607)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,229	0	0	0	0	0	0	0	0	0	7,229	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,090)	10,980	(24,655)	0	(19,765)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(54,593)	76,764	(262,706)	0	(240,535)	45							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr., Inc.	Jerseyville, IL	Wellington Mgt. Co.	Chesterfield, MO	Management Co.
David L. Kamler	20.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	20.00	Spanish Lake Nursing and Rehabilitation Ctr.	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
				NW Rehab, L.L.C.	Alton, IL	Therapy Co.
				Three Amigos, L.L.C.	Alton, IL	Real Estate Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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 Company	60.00%	\$ 49	\$	49	1
2	V	6 See Schedule VIII		Wellington Management Company	60.00%	406		406	2
3	V	17 See Schedule VIII		Wellington Management Company	60.00%	26,580		26,580	3
4	V	19 See Schedule VIII		Wellington Management Company	60.00%	297		297	4
5	V	20 See Schedule VIII		Wellington Management Company	60.00%	2,090		2,090	5
6	V	21 See Schedule VIII		Wellington Management Company	60.00%	21,006		21,006	6
7	V	22 See Schedule VIII		Wellington Management Company	60.00%	8,125		8,125	7
8	V	24 See Schedule VIII		Wellington Management Company	60.00%	4,038		4,038	8
9	V	25 See Schedule VIII		Wellington Management Company	60.00%	1,425		1,425	9
10	V	26 See Schedule VIII		Wellington Management Company	60.00%	1,768		1,768	10
11	V	30 See Schedule VIII		Wellington Management Company	60.00%	3,613		3,613	11
12	V	32 See Schedule VIII		Wellington Management Company	60.00%	138		138	12
13	V	34 See Schedule VIII		Wellington Management Company	60.00%	7,229		7,229	13
14	Total		\$			\$ 76,764	\$ *	76,764	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	\$ 24,000	Wellington Management Company	60.00%	\$ 24,000	\$	15
16	V	17 Management Fees	148,323	Wellington Management Company	60.00%		(148,323)	16
17	V	17 Management Fees	57,681	Health Care Financial, LLC	40.00%	58,262	581	17
18	V	19 Professional Services	42,487	C.J. Schlosser & Company, LLC	40.00%		(42,487)	18
19	V	10a Therapy Services	376,087	NW Rehab, LLC	100.00%	358,265	(17,822)	19
20	V	32 Interest	17,055	John H. Rothert	60.00%		(17,055)	20
21	V	32 Interest	3,800	J. Terry Dooling	20.00%		(3,800)	21
22	V	32 Interest	3,800	David L. Kamler	20.00%		(3,800)	22
23	V	18 Director's Fees	18,000	John H. Rothert	60.00%		(18,000)	23
24	V	18 Director's Fees	6,000	J. Terry Dooling	20.00%		(6,000)	24
25	V	18 Director's Fees	6,000	David L. Kamler	20.00%		(6,000)	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		\$ 703,233			\$ 440,527	\$ * (262,706)	39

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cent # 0039347 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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	123,420	7.09	17.72	Salary	\$ 26,580	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	\$ 26,580		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning:

1/1/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	19,475,962	6	\$ 278	\$ 3,451,152	\$ 49	1
2	6	Maintenance	Accumulated Costs	19,475,962	6	2,291	3,451,152	406	2
3	17	Administrative	Accumulated Costs	19,475,962	6	150,000	150,000	3,451,152	26,580
4	19	Professional Services	Accumulated Costs	19,475,962	6	1,675	3,451,152	297	4
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs	19,475,962	6	11,792	3,451,152	2,090	5
6	21	Clerical and General Office Exp.	Accumulated Costs	19,475,962	6	118,543	84,081	3,451,152	21,006
7	22	Employee Benefits and PR Taxes	Accumulated Costs	19,475,962	6	45,854	3,451,152	8,125	7
8	24	Travel & Seminar	Accumulated Costs	19,475,962	6	22,787	3,451,152	4,038	8
9	25	Other Admin Staff Transport	Accumulated Costs	19,475,962	6	8,044	3,451,152	1,425	9
10	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	19,475,962	6	9,978	3,451,152	1,768	10
11	30	Depreciation	Accumulated Costs	19,475,962	6	20,387	3,451,152	3,613	11
12	32	Interest Expense	Accumulated Costs	19,475,962	6	779	3,451,152	138	12
13	34	Rent - Facility & Ground	Accumulated Costs	19,475,962	6	40,796	3,451,152	7,229	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					\$ 433,204	\$ 234,081	\$ 76,764	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	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Ford Credit		X	Van Loan	\$596.16	3/15/04	\$ 33,260	\$ 8,196	3/14/09	2.9000	\$ 342	1							
2	Capmark Finance, Inc		X	Refinance Mortgage	\$13,209.94	11/30/06	2,415,500	2,390,933	11/30/41	5.6500	134,409	2							
3									Loan Cost Amortization		1,391	3							
4									Interest Income		(6,090)	4							
5									Home Office Allocation		138	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$13,806.10		\$ 2,448,760	\$ 2,399,129			\$ 130,190	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 2,448,760	\$ 2,399,129			\$ 130,190	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 12,069 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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. 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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

1/1/2007

Ending:

12/31/2007**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 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	\$	\$ 529,148	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed		1994		3,247		10			3,247	9
10	Air Conditioner		1994		76,140		10			76,140	10
11	Cabinets		1994		6,809	340	20	340		4,511	11
12	Doors		1994		2,337	117	20	117		1,558	12
13	Electrical		1994		4,601	230	20	230		3,024	13
14	Flooring		1994		25,850		10			25,850	14
15	Exterior Remodeling		1994		4,468	298	15	298		3,971	15
16	Interior Remodeling		1994		66,214	4,386	15	4,386		58,132	16
17	Nurse Call Station		1994		1,960	131	15	131		1,731	17
18	Plumbing		1994		6,619	331	20	331		4,377	18
19	Roof		1994		29,619		10			29,619	19
20	Windows/Gutter		1994		60,254	4,017	15	4,017		53,893	20
21	Siding		1994		15,818	1,055	15	1,055		13,783	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		2,801		5			2,801	24
25	Flooring		1995		938		10			938	25
26	Metal Doors & Frames		1996		953	48	20	48		549	26
27	Metal Carport		1997		972	65	15	65		664	27
28	Carpet		1997		2,310		5			2,310	28
29	Dining Room Chair Rail		1997		2,230	149	15	149		1,487	29
30	Wallpapering		1997		4,830		5			4,830	30
31	Fire Doors		1997		593	30	20	30		296	31
32	Foliage & Fountains		1997		1,657	41	10	41		1,657	32
33	Interior Painting		1997		514		5			514	33
34	Shed		1997		315	28	10	28		315	34
35	Door Alarm System		1997		7,840	719	10	719		7,840	35
36	Sidewalk Replacement		1997		650	43	15	43		436	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:

1/1/2007

Ending:

12/31/2007**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		\$ 1,983	37
38	Wallpapering	1998	1,493		5			1,493	38
39	Shower Room Remodeling	1998	1,199	60	20	60		560	39
40	Mini Blinds Installed	1998	509	51	10	51		503	40
41	Shelving	1998	566	28	20	28		266	41
42	Baseboard Remodeling	1998	820	82	10	82		813	42
43	Water Heater	1998	6,040	403	15	403		3,725	43
44	Folding Doors	1998	456	46	10	46		422	44
45	Door Installed	1998	208	21	10	21		191	45
46	Wall Mounted Laundry Tub	1998	181	9	20	9		90	46
47	Shower Flooring	1998	401	40	10	40		364	47
48	Shed	1998	185	19	10	19		169	48
49	Flooring	1998	293	29	10	29		275	49
50	Air Conditioning Unit	2000	557	56	10	56		422	50
51	Asphalt Parking Lot	2000	2,360	236	10	236		1,731	51
52	Fire Doors	2001	1,534	102	15	102		673	52
53	Signage	2001	3,318		5			3,318	53
54	Cove Base	2001	1,006	101	10	101		661	54
55	Window Treatments	2001	7,272		5			7,272	55
56	Wallpapering	2001	37,693		5			37,693	56
57	Lobby Carpet	2001	1,433		5			1,433	57
58	Air Conditioning Unit	2001	1,696	170	10	170		1,102	58
59	Home Office Wallpapering	1999	471		5			471	59
60	Cove Base	2002	604	60	10	60		312	60
61	Wallpapering	2002	4,462	231	5	231		4,462	61
62	Air Conditioning Unit	2002	1,981	198	10	198		1,123	62
63	Blinds	2002	512	9	5	9		512	63
64	Flooring & Cove Base	2002	1,630	163	10	163		964	64
65	Wall Guard	2002	1,927	128	15	128		749	65
66	Fire Doors	2002	1,042	69	15	69		382	66
67	A/C/Heat Pump Units	2002	1,580	158	10	158		856	67
68	Home Office Light Fixtures	2002	171		10	17	17	101	68
69	Air Conditioning Unit	2003	3,110	311	10	311		1,362	69
70	TOTAL (lines 4 thru 69)		\$ 1,415,863	\$ 53,506		\$ 53,523	\$ 17	\$ 942,315	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:

1/1/2007

Ending:

12/31/2007**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,415,863	\$ 53,506		\$ 53,523	\$ 17	\$ 942,315	1
2	11 Fire Doors	2003	5,950	397	15	397		1,686	2
3	Home Office Cabinets	2003	739		10	74	74	333	3
4	Closet Doors - Resident Rooms	2004	3,628	242	15	242		849	4
5	Wiring Outside Lights	2004	1,145	57	10	57		224	5
6	Tile	2004	878	88	10	88		344	6
7	Commercial Water Heater	2004	7,664	766	10	766		2,682	7
8	Floor Tile	2004	1,186	119	10	119		366	8
9	66 Gallon Water Heater	2004	931	93	10	93		287	9
10	Patio & Sidewalks	2004	14,316	954	15	954		3,181	10
11	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		354	11
12	Gravel Parking Lot	2004	3,355	671	5	671		2,516	12
13	Range Hood	2005	831	41	20	41		125	13
14	Closet Doors - Resident Rooms	2005	3,689	369	10	369		1,024	14
15	Outside Light Fixtures	2005	2,025	203	10	203		550	15
16	Air Conditioning Unit	2005	7,609	761	10	761		1,873	16
17	Generator Wiring	2005	1,660	332	5	332		830	17
18	Electrical Work	2005	5,528	276	20	276		691	18
19	Tile & Cove Base	2005	2,064	206	10	206		499	19
20	Heating/Cooling Unit	2005	558	112	5	112		270	20
21	Wallpaper	2005	810	162	5	162		365	21
22	Therapy Room Cabinets	2005	1,200	80	15	80		160	22
23	New Roof-200 & 500 Wings	2005	74,745	4,983	15	4,983		11,212	23
24	Wall Guard	2006	570	38	15	38		70	24
25	6 Oak Doors	2006	3,469	231	15	231		366	25
26	Smoke Detectors	2006	683	68	10	68		114	26
27	Exhaust Fans for Kitchen	2006	1,035	104	10	104		129	27
28	New Roof-300 Wing	2007	30,200	2,517	10	2,517		2,517	28
29	Shower & Wall Remodel	2006	5,510	253	20	253		253	29
30	Water Heaters	2006	1,696	170	10	170		264	30
31	Air Conditioning Unit	2006	3,413	580	10	580		859	31
32	Storage Shed	2006	1,584	158	10	158		244	32
33	Fire Doors	2006	4,939	329	15	329		384	33
34	TOTAL (lines 1 thru 33)		\$ 1,610,993	\$ 68,967		\$ 69,058	\$ 91	\$ 977,936	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 1,610,993	\$ 68,967		\$ 69,058	\$ 91	\$ 977,936	1
2	Patio and Sidewalks	2006	9,566	638	15	638		961	2
3	Wallpaper	2007	779	156	5	156		156	3
4	Upgrade Controls on Call System	2007	1,814	151	10	151		151	4
5	Exhaust Fan Replacement	2007	3,862	64	10	64		64	5
6	Pac-Van 12x36 Office Trailer	2007	18,313	76	20	76		76	6
7	New Office Telecommunication Work	2007	2,075		10				7
8	Interior Remodeling-Shower Room	2007	20,896	292	20	292		292	8
9	Water Heaters	2007	10,972	826	10	826		826	9
10	Doors - Metal	2007	4,450	142	20	142		142	10
11	Doors - Wood & Vinyl	2007	2,238	95	15	95		95	11
12	Air Conditioning Units	2007	3,512	269	5	269		269	12
13	Flooring	2007	10,399	255	10	255		255	13
14	Light Fixtures	2007	1,794	39	10	39		39	14
15	Home Office New Carpet	2007	1,111		10	56	56	56	15
16	Landscaping-Sign Area	2007	2,575	150	10	150		150	16
17	Repaved Driveway	2007	4,750	247	8	247		247	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)		\$ 1,710,098	\$ 72,367		\$ 72,514	\$ 147	\$ 981,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 186,153	\$ 17,554	\$ 18,159	\$ 605	5-20	\$ 99,110	71
72	Current Year Purchases	29,874	1,313	1,391	78	5-15	1,392	72
73	Fully Depreciated Assets	343,736	2,769	2,996	227	5-10	343,735	73
74								74
75	TOTALS	\$ 559,763	\$ 21,636	\$ 22,546	\$ 910		\$ 444,237	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	\$ 34,307	76
77	Home Office Admin	2000 Ford Taurus	2004	4,220				4	4,220	77
78	Home Office Admin	2001 Infiniti	2004	2,329		582	582	4	2,281	78
79	See Schedule Attached			8,940		1,974	1,974	4	1,719	79
80	TOTALS			\$ 51,288	\$ 8,950	\$ 11,506	\$ 2,556		\$ 42,527	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)	\$ 2,348,822	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,953	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,566	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,468,479	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

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

If NO, see instructions. YES NO

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

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: \$ 1,608 Description: Gas Tank \$36; Dishwasher \$73; Postage Machine \$567; Copier \$932

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		601		601
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,200		7,200
6	Transportation				
7	Contractual Payments		440		440
8	CNA Competency Tests		662		662
9	TOTALS	\$	\$ 8,903	\$	\$ 8,903
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,903		

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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	22

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,8	4482 hrs	\$ 135,058		\$	\$	4,482	\$ 135,058	1
2	Licensed Speech and Language Development Therapist	10a,8	1656 hrs	66,622			814	1,656	67,436	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	4507 hrs	163,442			2,548	4,507	165,990	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 prescrpts				113,881		113,881	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				15,829			15,829	
	Other (specify): X-Rays, Spec. Mattress	39,3				12,441			12,441	13
14	TOTAL			\$ 365,122		\$ 28,270	\$ 117,243	10,645	\$ 510,635	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: 1/1/2007Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 79,355	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>27,000</u>)	769,719		3
4	Supply Inventory (priced at <u>cost</u>)	16,918		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,660		6
7	Other Prepaid Expenses	3,261		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 885,913	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	99,007		13
14	Buildings, at Historical Cost	1,633,471		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	581,919		16
17	Accumulated Depreciation (book methods)	(1,445,316)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	119,743		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	47,196		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,056,220	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,942,133	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 707,408	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,166		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Dut To Related Parties</u>	387,850		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,296,962	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	200,988		39
40	Mortgage Payable	2,437,748		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,638,736	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,935,698	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,993,565)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,942,133	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,994,055)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,994,055)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	490	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 490	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,993,565)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 1/1/2007Ending: 12/31/2007**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,724,666	1
2	Discounts and Allowances for all Levels	(308,223)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,416,443	3
B. Ancillary Revenue			
4	Day Care	2,070	4
5	Other Care for Outpatients		5
6	Therapy	615,563	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 617,633	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,758	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	7,454	19
20	Radiology and X-Ray	938	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,150	23
D. Non-Operating Revenue			
24	Contributions	5,288	24
25	Interest and Other Investment Income***	6,090	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,378	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	12,100	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,100	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,073,704	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	801,478	31
32	Health Care	1,840,892	32
33	General Administration	910,245	33
B. Capital Expense			
34	Ownership	317,415	34
C. Ancillary Expense			
35	Special Cost Centers	147,886	35
36	Provider Participation Fee	55,298	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,073,214	40
41	Income before Income Taxes (line 30 minus line 40)**	490	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 490	43

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

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

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

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

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	2,491	2,494	\$ 62,497	\$ 25.06	1
2	Assistant Director of Nursing	1,914	2,302	47,018	20.42	2
3	Registered Nurses	7,999	8,551	166,262	19.44	3
4	Licensed Practical Nurses	17,846	18,894	296,413	15.69	4
5	CNAs & Orderlies	72,872	76,936	655,204	8.52	5
6	CNA Trainees					6
7	Licensed Therapist	199	199	6,857	34.46	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,465	5,821	59,807	10.27	10
11	Social Service Workers	1,799	2,092	31,680	15.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,928	23,563	199,035	8.45	15
16	Dishwashers					16
17	Maintenance Workers	2,257	2,429	35,881	14.77	17
18	Housekeepers	12,887	13,795	111,188	8.06	18
19	Laundry	9,485	10,007	71,427	7.14	19
20	Administrator	2,080	2,080	69,375	33.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,158	4,513	65,435	14.50	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	1,194	1,511	14,661	9.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,574	175,187	\$ 1,892,740 *	\$ 10.80	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	101	\$ 5,546	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	12	636	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,082	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	521	11,3	44
45	Social Service Consultant	8	521	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	24,000	10,3	47
48					48
49	TOTAL (lines 35 - 48)	129	\$ 41,906		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. 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 Haar	Administrator	0.00	\$ 69,375	Workers' Compensation Insurance	\$ 86,915	IDPH License Fee	\$ 995					
				Unemployment Compensation Insurance	30,564	Advertising: Employee Recruitment	9,840					
				FICA Taxes	143,133	Health Care Worker Background Check	1,556					
				Employee Health Insurance	29,474	(Indicate # of checks performed <u>97</u>)						
				Employee Meals		Resident Background Checks <u>70</u>	1,120					
				Illinois Municipal Retirement Fund (IMRF)*		Dues Subscriptions & Manuals	2,979					
				Staff Relations	10,435	Licenses & Fees	381					
				Employee Dental/Vision Insurance	2,021	Bank Service Charges	2,775					
				Home Office Employee Benefits	8,125	IHCA Dues	3,456					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 69,375	TOTAL (agree to Schedule V, line 22, col.8)			\$ 310,667	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,192		
(List each licensed administrator separately.)								Less: Public Relations Expense ()				
								Non-allowable advertising ()				
								Yellow page advertising ()				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**				
Description			Amount	Description			Line #	Amount	Description			Amount
Wellington Management Co. - Management Fees			\$ 148,323	Section N/A					Out-of-State Travel			\$
Health Care Financial, LLC - Management Fees			57,681						In-State Travel			4,850
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 206,004	TOTAL					Seminar Expense			405
(Attach a copy of any management service agreement)									Home Office Travel & Seminar			4,038
C. Professional Services												
Vendor/Payee	Type		Amount						Entertainment Expense ()			
C.J. Schlosser & Co., LLC	Accounting Services		\$ 42,487						TOTAL (agree to Sch. V, line 24, col. 8)			\$ 9,293
Hughes & Associates, CPA	Audit Fees		5,550									
Elvidge Kelley	Legal Services		1,492									
Burnside, Johnston, Choisser	Legal Services		172									
TOTAL (agree to Schedule V, line 19, column 3)			\$ 49,701									
(If total legal fees exceed \$5,000, attach copy of invoices.)												

* 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	5-13 Amount of Expense Amortized Per Year								
					6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011	14 FY2012
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 Healthcare Association \$3,456
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,602 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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? 47.86%
 - 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: May, Cocagne & King The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet available
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

MONTGOMERY NURSING & REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2007

<u>DESCRIPTION</u>	<u>LINE #</u>		<u>INCREASE (DECREASE)</u>
DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS	20	XIXFp10	(300)
NURSE AIDE TRAINING	13		300
To reclass expenses for CNA class test fees to proper line			
NURSE AIDE TRAINING	13	XIXGp1	60
TRAVEL & SEMINAR	24		(60)
To reclass CNA class book fees to proper line			
ADMINISTRATIVE	17	VIbp1	(2,658)
ACTIVITIES	11		281
DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS	20		20
MAINTENANCE	6		1,910
PROFESSIONAL SERVICES	19		447
To reclass various expenses to proper lines			
NURSE AIDE TRAINING	13	XIIIp1	7,200
NURSING & MEDICAL RECORDS	10		(7,200)
To reclass CNA trainer wages			

MONTGOMERY NURSING & REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2007

Miscellaneous Income	294
Reimbursement from the state for vocational rehab	900
Reimbursement from employee for training	955
CNA repaid bonus	500
MPIC Insurance dividend	8,311
Seniorcise Program	<u>1,140</u>
	<u><u>12,100</u></u>

Montgomery Nursing & Rehabilitation Center
Attachment to Sch. XI, Part D
December 31, 2007

Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make, & Year</u>	<u>Year Acquired</u>	<u>Cost</u>	<u>Current Book Depreciation</u>	<u>Straight Line Depreciation</u>	<u>Adjustments</u>	<u>Life In Years</u>	<u>Accumulated Depreciation</u>
2004 Infiniti	2006	3,438	-	688	688	4	802
2004 Jaguar	2007	5,502	-	917	917	4	917
1998 Jaguar-sold in 2007	2004	-	-	332	332	4	-
2000 Caravan-sold in 2007	2005	-	-	37	37	4	-
		<u>8,940</u>	<u>-</u>	<u>1,974</u>	<u>1,974</u>		<u>1,719</u>

Montgomery Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2007

BOOK TO TAX NET INCOME RECONCILIATION:

BOOK NET INCOME (LOSS)	490
DEPRECIATION ADJUSTMENT	(106)
MISC. NON-DEDUCTIBLE EXPENSES	11,810
CONVERSION TO CASH BASIS ADJUSTMENTS	82,508
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u>94,702</u>