



Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

# 0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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 1/24/08

	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>22</u>	<u>8,029</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>80</u>	Intermediate (ICF)	<u>88</u>	<u>32,024</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>110</u>	<u>40,053</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>196</u>	<u>892</u>	<u>4,126</u>	<u>5,214</u>	8
9	SNF/PED					9
10	ICF	<u>17,263</u>	<u>12,636</u>	<u>322</u>	<u>30,221</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,459</u>	<u>13,528</u>	<u>4,448</u>	<u>35,435</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.47%

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 4,126

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Centre # 0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	216,529	14,232	5,817	236,578		236,578		236,578		1
2	Food Purchase		182,531		182,531		182,531	(89)	182,442		2
3	Housekeeping	116,035	16,606		132,641		132,641		132,641		3
4	Laundry	72,821	11,707		84,528		84,528		84,528		4
5	Heat and Other Utilities			124,287	124,287		124,287		124,287		5
6	Maintenance	47,222	12,887	49,821	109,930	1,667	111,597	481	112,078		6
7	Other (specify):* <b>Waste Removal</b>			9,191	9,191		9,191		9,191		7
8	<b>TOTAL General Services</b>	<b>452,607</b>	<b>237,963</b>	<b>189,116</b>	<b>879,686</b>	<b>1,667</b>	<b>881,353</b>	<b>392</b>	<b>881,745</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,447,135	91,599	38,874	1,577,608	(4,800)	1,572,808		1,572,808		10
10a	Therapy		3,584	414,340	417,924		417,924	12,355	430,279		10a
11	Activities	54,111	6,939	400	61,450	435	61,885		61,885		11
12	Social Services	35,328	81	400	35,809		35,809		35,809		12
13	CNA Training			1,595	1,595	5,220	6,815		6,815		13
14	Program Transportation		6,878		6,878		6,878		6,878		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,536,574</b>	<b>109,081</b>	<b>465,209</b>	<b>2,110,864</b>	<b>855</b>	<b>2,111,719</b>	<b>12,355</b>	<b>2,124,074</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	73,833	16,119	238,139	328,091	(2,809)	325,282	(94,672)	230,610		17
18	Directors Fees										18
19	Professional Services			69,546	69,546	792	70,338	(52,986)	17,352		19
20	Dues, Fees, Subscriptions & Promotions			63,525	63,525	(320)	63,205	(34,211)	28,994		20
21	Clerical & General Office Expenses	65,900	20,442	49,887	136,229		136,229	26,937	163,166		21
22	Employee Benefits & Payroll Taxes			310,937	310,937		310,937	10,820	321,757		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,921	14,921	(185)	14,736	(990)	13,746		24
25	Other Admin. Staff Transportation							3,231	3,231		25
26	Insurance-Prop.Liab.Malpractice			49,864	49,864		49,864	1,538	51,402		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>139,733</b>	<b>36,561</b>	<b>796,819</b>	<b>973,113</b>	<b>(2,522)</b>	<b>970,591</b>	<b>(140,333)</b>	<b>830,258</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,128,914</b>	<b>383,605</b>	<b>1,451,144</b>	<b>3,963,663</b>		<b>3,963,663</b>	<b>(127,586)</b>	<b>3,836,077</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center #0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			119,000	119,000		119,000	3,847	122,847		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			157,549	157,549		157,549	(28,088)	129,461		32
33	Real Estate Taxes			47,524	47,524		47,524		47,524		33
34	Rent-Facility & Grounds							12,737	12,737		34
35	Rent-Equipment & Vehicles			4,491	4,491		4,491		4,491		35
36	Other (specify):* <b>Mortgage Ins.</b>			11,900	11,900		11,900		11,900		36
37	<b>TOTAL Ownership</b>			340,464	340,464		340,464	(11,504)	328,960		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			907	907		907		907		38
39	Ancillary Service Centers		132,067	33,636	165,703		165,703		165,703		39
40	Barber and Beauty Shops		1,181		1,181		1,181		1,181		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			60,080	60,080		60,080		60,080		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		133,248	94,623	227,871		227,871		227,871		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,128,914	516,853	1,886,231	4,531,998		4,531,998	(139,090)	4,392,908		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	(5,259)	32		10
11	Discounts, Allowances, Rebates & Refunds	(89)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,861)	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	(862)	20		18
19	Entertainment	(4,878)	24		19
20	Contributions	(75)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,324)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,131)	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	(3,480)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (53,959)		\$	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)	(85,131)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (85,131)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (139,090)		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.

		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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Eliminate PAC Dues, including Lobbying portion	\$ (2,485)	20
2	Eliminate 2009 IDPH License paid in 2008	(995)	20
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5			
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48	<b>Total</b>	(3,480)	
49			

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Montgomery Nursing &amp; Rehabilitation Center

# 0039347

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	(89)	0	0	0	0	0	0	0	0	0	0	(89)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	481	0	0	0	0	0	0	0	0	0	481	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(89)</b>	<b>481</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>392</b>	<b>8</b>
	<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	12,355	0	0	0	0	0	0	0	0	12,355	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>	<b>0</b>	<b>0</b>	<b>12,355</b>	<b>0</b>	<b>12,355</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	65,984	(160,656)	0	0	0	0	0	0	0	0	(94,672)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,324)	2,361	(49,023)	0	0	0	0	0	0	0	0	(52,986)	19
20	Fees, Subscriptions & Promotions	(37,409)	3,198	0	0	0	0	0	0	0	0	0	(34,211)	20
21	Clerical & General Office Expenses	0	26,937	0	0	0	0	0	0	0	0	0	26,937	21
22	Employee Benefits & Payroll Taxes	0	10,820	0	0	0	0	0	0	0	0	0	10,820	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,878)	3,888	0	0	0	0	0	0	0	0	0	(990)	24
25	Other Admin. Staff Transportation	0	3,231	0	0	0	0	0	0	0	0	0	3,231	25
26	Insurance-Prop.Liab.Malpractice	0	1,538	0	0	0	0	0	0	0	0	0	1,538	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(48,611)</b>	<b>117,957</b>	<b>(209,679)</b>	<b>0</b>	<b>(140,333)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(48,700)</b>	<b>118,438</b>	<b>(197,324)</b>	<b>0</b>	<b>(127,586)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

# 0039347

Report Period Beginning:

1/1/2008 Ending:

12/31/2008

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	3,847	0	0	0	0	0	0	0	0	0	3,847	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,259)	92	(22,921)	0	0	0	0	0	0	0	0	(28,088)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	12,737	0	0	0	0	0	0	0	0	0	12,737	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>(5,259)</b>	<b>16,676</b>	<b>(22,921)</b>	<b>0</b>	<b>(11,504)</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>(53,959)</b>	<b>135,114</b>	<b>(220,245)</b>	<b>0</b>	<b>(139,090)</b>	<b>45</b>							

**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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	5 See Schedule VIII	\$	Wellington Management Company	60.00%	\$	\$
2	V	6 See Schedule VIII		Wellington Management Company	60.00%	481	481
3	V	17 See Schedule VIII		Wellington Management Company	60.00%	65,984	65,984
4	V	19 See Schedule VIII		Wellington Management Company	60.00%	2,361	2,361
5	V	20 See Schedule VIII		Wellington Management Company	60.00%	3,198	3,198
6	V	21 See Schedule VIII		Wellington Management Company	60.00%	26,937	26,937
7	V	22 See Schedule VIII		Wellington Management Company	60.00%	10,820	10,820
8	V	24 See Schedule VIII		Wellington Management Company	60.00%	3,888	3,888
9	V	25 See Schedule VIII		Wellington Management Company	60.00%	3,231	3,231
10	V	26 See Schedule VIII		Wellington Management Company	60.00%	1,538	1,538
11	V	30 See Schedule VIII		Wellington Management Company	60.00%	3,847	3,847
12	V	32 See Schedule VIII		Wellington Management Company	60.00%	92	92
13	V	34 See Schedule VIII		Wellington Management Company	60.00%	12,737	12,737
14	Total		\$			\$ 135,114	\$ * 135,114

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

## 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	\$ 36,866	Wellington Management Company	60.00%	\$ 36,866	\$	15
16	V	17	Management Fees	171,460	Wellington Management Company	60.00%		(171,460)	16
17	V	17	Management Fees	66,679	Health Care Financial, LLC	40.00%	77,483	10,804	17
18	V	19	Professional Services	49,023	C.J. Schlosser & Company, LLC	40.00%		(49,023)	18
19	V	10a	Therapy Services	414,340	NW Rehab, LLC	100.00%	426,695	12,355	19
20	V	32	Interest	15,300	John H. Rothert	60.00%		(15,300)	20
21	V	32	Interest	3,810	J. Terry Dooling	20.00%		(3,810)	21
22	V	32	Interest	3,811	David L. Kamler	20.00%		(3,811)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 761,289				\$ 541,044	\$ * (220,245)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cent # 0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

## 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	284,839	7.52	18.81	Salary	\$ 65,984	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	\$ 65,984		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: 1/1/2008 Ending: 2/31/2008

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 707 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 20,655,999	6	\$	\$	3,885,059	\$ 0	1
2	6	Maintenance	Accumulated Costs 20,655,999	6	2,558		3,885,059	481	2
3	17	Administrative	Accumulated Costs 20,655,999	6	350,823		3,885,059	65,984	3
4	19	Professional Services	Accumulated Costs 20,655,999	6	12,552		3,885,059	2,361	4
5	20	Dues, Fees, Subs, & Promos	Accumulated Costs 20,655,999	6	17,005		3,885,059	3,198	5
6	21	Clerical & General Office Exp.	Accumulated Costs 20,655,999	6	143,216		3,885,059	26,937	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs 20,655,999	6	57,527		3,885,059	10,820	7
8	24	Travel & Seminar	Accumulated Costs 20,655,999	6	20,671		3,885,059	3,888	8
9	25	Other Admin Staff Transport	Accumulated Costs 20,655,999	6	17,181		3,885,059	3,231	9
10	26	Insurance- Prop, Liab, Malprac	Accumulated Costs 20,655,999	6	8,177		3,885,059	1,538	10
11	30	Depreciation	Accumulated Costs 20,655,999	6	20,454		3,885,059	3,847	11
12	32	Interest Expense	Accumulated Costs 20,655,999	6	487		3,885,059	92	12
13	34	Rent - Facility & Ground	Accumulated Costs 20,655,999	6	67,721		3,885,059	12,737	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				\$ 718,372	\$		\$ 135,114	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Ford Credit		X	Van Loan	\$596.16	3/15/04	\$ 33,260	\$ 1,187	3/14/09	2.9000	\$ 145					
2	Capmark Finance, Inc.		X	Refinance Mortgage	\$13,209.94	11/30/06	2,415,500	2,366,885	11/30/41	5.6500	133,091					
3									Loan Cost Amortization		1,392					
4									Interest Income		(5,259)					
5									Home Office Allocation		92					
<b>Working Capital</b>																
6											6					
7											7					
8											8					
9	<b>TOTAL Facility Related</b>				\$13,806.10		\$ 2,448,760	\$ 2,368,072			\$ 129,461					
<b>B. Non-Facility Related*</b>																
10											10					
11											11					
12											12					
13											13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$ 2,448,760	\$ 2,368,072			\$ 129,461					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,900 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Montgomery Nursing & Rehabilitation Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>44,523.96</u>	\$ <u>44,523.96</u>
2. _____	<u>Taylor Springs</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>44,523.96</u>	\$ <u>44,523.96</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 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:**

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:

**1/1/2008**

Ending:

**12/31/2008****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		\$ 962,086	\$ 38,483	25	\$ 38,483	\$	\$ 567,631	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		4,852	11
12	Doors		1994		2,337	117	20	117		1,675	12
13	Electrical		1994		4,601	230	20	230		3,254	13
14	Flooring		1994		25,850		10			25,850	14
15	Exterior Remodeling		1994		4,468	298	15	298		4,269	15
16	Interior Remodeling		1994		66,214	4,386	15	4,386		62,518	16
17	Nurse Call Station		1994		1,960	131	15	131		1,862	17
18	Plumbing		1994		6,619	331	20	331		4,708	18
19	Roof		1994		29,619		10			29,619	19
20	Windows/Gutter		1994		60,254	4,017	15	4,017		57,910	20
21	Siding		1994		15,818	1,054	15	1,054		14,837	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		2,974		5			2,974	24
25	Flooring		1995		938		10			938	25
26	Metal Doors & Frames		1996		953	48	20	48		596	26
27	Metal Carport		1997		972	65	15	65		729	27
28	Carpet		1997		2,310		5			2,310	28
29	Dining Room Chair Rail		1997		2,230	149	15	149		1,635	29
30	Wallpapering		1997		4,830		5			4,830	30
31	Fire Doors		1997		593	30	20	30		326	31
32	Foliage & Fountains		1997		1,657		10			1,657	32
33	Interior Painting		1997		514		5			514	33
34	Shed		1997		315		10			315	34
35	Door Alarm System		1997		7,840		10			7,840	35
36	Sidewalk Replacement		1997		650	43	15	43		480	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:

1/1/2008

Ending:

12/31/2008**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	\$	\$ 2,197	37
38	Wallpapering	1998	1,493		5			1,493	38
39	Shower Room Remodeling	1998	1,199	60	20	60		619	39
40	Mini Blinds Installed	1998	509	5	10	5		509	40
41	Shelving	1998	566	28	20	28		295	41
42	Baseboard Remodeling	1998	820	7	10	7		820	42
43	Water Heater	1998	6,040	403	15	403		4,127	43
44	Folding Doors	1998	456	34	10	34		456	44
45	Door Installed	1998	208	17	10	17		208	45
46	Wall Mounted Laundry Tub	1998	181	9	20	9		99	46
47	Shower Flooring	1998	401	37	10	37		401	47
48	Shed	1998	185	17	10	17		185	48
49	Flooring	1998	293	17	10	17		293	49
50	Air Conditioning Unit	2000	557	56	10	56		478	50
51	Asphalt Parking Lot	2000	2,360	236	10	236		1,967	51
52	Fire Doors	2001	1,535	102	15	102		776	52
53	Signage	2001	3,318		5			3,318	53
54	Cove Base	2001	1,006	101	10	101		761	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		1,272	58
59	Home Office Wallpapering	1999	500		5			500	59
60	Cove Base	2002	604	60	10	60		373	60
61	Wallpapering	2002	4,462		5			4,462	61
62	Air Conditioning Unit	2002	1,981	198	10	198		1,321	62
63	Blinds	2002	512		5			512	63
64	Flooring & Cove Base	2002	1,630	163	10	163		1,127	64
65	Wall Guard	2002	1,927	128	15	128		878	65
66	Fire Doors	2002	1,042	69	15	69		451	66
67	A/C/Heat Pump Units	2002	1,580	158	10	158		1,014	67
68	Home Office Light Fixtures	2002	181		10	18	18	125	68
69	Air Conditioning Unit	2003	3,110	311	10	311		1,673	69
70	TOTAL (lines 4 thru 69)		\$ 1,416,076	\$ 52,322		\$ 52,340	\$ 18	\$ 994,865	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:

**1/1/2008**

Ending:

**12/31/2008****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>		\$ 1,416,076	\$ 52,322		\$ 52,340	\$ 18	\$ 994,865	1
2	11 Fire Doors	2003	5,950	397	15	397		2,082	2
3	Home Office Cabinets	2003	785		10	78	78	432	3
4	Closet Doors - Resident Rooms	2004	3,628	242	15	242		1,090	4
5	Wiring Outside Lights	2004	1,145	57	10	57		281	5
6	Tile	2004	878	88	10	88		432	6
7	Commercial Water Heater	2004	7,664	766	10	766		3,449	7
8	Floor Tile	2004	1,186	119	10	119		484	8
9	66 Gallon Water Heater	2004	931	93	10	93		380	9
10	Patio & Sidewalks	2004	14,316	954	15	954		4,136	10
11	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		456	11
12	Gravel Parking Lot	2004	3,355	671	5	671		3,187	12
13	Range Hood	2005	832	42	20	42		166	13
14	Closet Doors - Resident Rooms	2005	3,689	369	10	369		1,393	14
15	Outside Light Fixtures	2005	2,025	203	10	203		752	15
16	Air Conditioning Unit	2005	7,609	761	10	761		2,634	16
17	Generator Wiring	2005	1,660	332	5	332		1,162	17
18	Electrical Work	2005	5,528	276	20	276		967	18
19	Tile & Cove Base	2005	2,064	206	10	206		705	19
20	Heating/Cooling Unit	2005	558	112	5	112		381	20
21	Wallpaper	2005	810	162	5	162		527	21
22	Therapy Room Cabinets	2005	1,200	80	15	80		240	22
23	New Roof-200 & 500 Wings	2005	74,745	4,983	15	4,983		16,195	23
24	Wall Guard	2006	570	38	15	38		108	24
25	6 Oak Doors	2006	3,469	231	15	231		597	25
26	Smoke Detectors	2006	683	68	10	68		182	26
27	Exhaust Fans for Kitchen	2006	1,034	103	10	103		233	27
28	New Roof-300 Wing	2007	30,200	3,020	10	3,020		5,537	28
29	Shower & Wall Remodel	2007	5,510	275	20	275		528	29
30	Water Heaters	2006	1,696	170	10	170		433	30
31	Air Conditioning Unit	2006	3,414	580	10	580		1,438	31
32	Storage Shed	2006	1,583	158	10	158		402	32
33	Fire Doors	2006	4,939	329	15	329		713	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,611,252	\$ 68,308		\$ 68,404	\$ 96	\$ 1,046,567	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:

**1/1/2008**

Ending:

**12/31/2008****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 12B, Carried Forward</b>		\$ 1,611,252	\$ 68,308		\$ 68,404	\$ 96	\$ 1,046,567	1
2	Patio and Sidewalks	2006	9,566	638	15	638		1,598	2
3	Wallpaper	2007	779	156	5	156		311	3
4	Upgrade Controls on Call System	2007	1,814	181	10	181		333	4
5	Exhaust Fan Replacement	2007	3,862	386	10	386		451	5
6	Pac-Van 12x36 Office Trailer	2007	18,313	916	20	916		992	6
7	New Office Telecommunication Work	2007	2,075	208	10	208		208	7
8	Interior Remodeling-Shower Room	2007	20,896	1,045	20	1,045		1,337	8
9	Water Heaters	2007	10,972	1,097	10	1,097		1,923	9
10	Doors - Metal	2007	4,450	223	20	223		364	10
11	Doors - Wood & Vinyl	2007	2,238	149	15	149		244	11
12	Air Conditioning Units	2007	3,512	702	5	702		972	12
13	Flooring	2007	10,399	1,040	10	1,040		1,294	13
14	Light Fixtures	2007	1,794	179	10	179		219	14
15	Home Office New Carpet	2007	1,180		10	118	118	177	15
16	Landscaping - Sign Area	2007	2,575	257	10	257		408	16
17	Repaved Driveway	2007	4,750	594	8	594		841	17
18	Flooring	2008	132,076	7,477	10	7,477		7,477	18
19	Wallpapering	2008	45,923	5,651	5	5,651		5,651	19
20	Electrical Work	2008	11,765	337	20	337		337	20
21	5 A/C Units & Installation	2008	8,021	469	10	469		469	21
22	Facility Signage	2008	8,602	784	5	784		784	22
23	8 Oak Doors	2008	4,659	103	15	103		103	23
24	In Wall Fountain-Labor & Materials	2008	5,321	380	7	380		380	24
25	Corner Guards	2008	2,226	167	10	167		167	25
26	Handrails & Hardware	2008	8,950	448	15	448		448	26
27	Chair Rail Materials	2008	807	54	10	54		54	27
28	Cabinets, Countertop, & Sinks	2008	28,200	1,410	15	1,410		1,410	28
29	Shower Room Plumbing	2008	856	29	20	29		29	29
30	Hot Water Pump	2008	1,425	119	10	119		119	30
31	2 A/C Heat Units	2008	957	80	5	80		80	31
32	Door Guards	2008	1,041	43	10	43		43	32
33	Storage Shed	2008	842	28	10	28		28	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,972,098	\$ 93,658		\$ 93,872	\$ 214	\$ 1,075,818	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	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,972,098	\$ 93,658		\$ 93,872	\$ 214	\$ 1,075,818	1
2	5 Shaped Cornices	2008	3,034	101	10	101		101	2
3	Cabinet Installation	2008	3,320	37	15	37		37	3
4	2 New Sidewalks & generator pad	2008	2,050	128	15	128		128	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,980,502	\$ 93,924		\$ 94,138	\$ 214	\$ 1,076,084	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: 1/1/2008 Ending: 12/31/2008

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	\$ 209,636	\$ 19,590	\$ 20,358	\$ 768	5-20 yrs	\$ 113,073	71
72	Current Year Purchases	74,106	3,687	3,713	26	5-15 yrs	3,713	72
73	Fully Depreciated Assets	350,540	307	431	124	5-10 yrs	350,540	73
74								74
75	TOTALS	\$ 634,282	\$ 23,584	\$ 24,502	\$ 918		\$ 467,326	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	\$ 1,492	\$ 1,492	\$	4	\$ 35,799	76
77	See Schedule Attached			16,809		2,715	2,715	4	7,447	77
78								4		78
79								4		79
80	TOTALS			\$ 52,608	\$ 1,492	\$ 4,207	\$ 2,715		\$ 43,246	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)		\$ 2,695,065	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 119,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 122,847	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 3,847	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,586,656	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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  NO

16. Rental Amount for movable equipment: \$ 4,491      Description: Postage Machine \$764 ; Copier \$3,727

(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: 1/1/2008 Ending: 12/31/2008

**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		155		155
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		4,800		4,800
6	Transportation				
7	Contractual Payments		1,055		1,055
8	CNA Competency Tests		805		805
9	TOTALS	\$	\$ 6,815	\$	\$ 6,815
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,815		

**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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>14</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	4642 hrs	\$ 154,060		\$	\$	4,642	\$ 154,060	1
2	Licensed Speech and Language Development Therapist	10a,8	1496 hrs	70,117				1,496	70,117	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	5381 hrs	202,518			3,584	5,381	206,102	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				132,067		132,067	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Rays</u>					5,325			5,325	12
13	Other (specify): <u>Lab Fees, Spec. Mattre</u>	39,3 39,3				12,877 15,434			15,434	13
14	TOTAL			\$ 426,695		\$ 33,636	\$ 135,651	11,519	\$ 583,105	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: 1/1/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008

(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	\$ 1,584	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 35,009 )	839,770		3
4	Supply Inventory (priced at cost )	17,250		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,957		6
7	Other Prepaid Expenses	414		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>	\$ 894,975	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	101,056		13
14	Buildings, at Historical Cost	1,901,494		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	654,400		16
17	Accumulated Depreciation (book methods)	(1,564,316)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	147,799		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	45,805		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,306,438	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,201,413	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 716,207	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,725		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,351		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000		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>	539,525		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,458,808	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	193,979		39
40	Mortgage Payable	2,412,320		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>	\$ 2,606,299	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,065,107	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,863,694)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,201,413	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,993,565)	1
2	Restatements (describe):		2
3	Income effect of prior year adjustment not included	(39,392)	3
4	on prior year cost report		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,032,957)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	169,263	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)	\$ 169,263	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,863,694)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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	\$ 4,530,358	1
2	Discounts and Allowances for all Levels	(489,965)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,040,393	3
<b>B. Ancillary Revenue</b>			
4	Day Care	1,170	4
5	Other Care for Outpatients		5
6	Therapy	636,876	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 638,046	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,925	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	9,176	19
20	Radiology and X-Ray	2,926	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,027	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	630	24
25	Interest and Other Investment Income***	5,259	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,889	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	1,906	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,906	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,701,261	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	879,686	31
32	Health Care	2,110,864	32
33	General Administration	973,113	33
<b>B. Capital Expense</b>			
34	Ownership	340,464	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	167,791	35
36	Provider Participation Fee	60,080	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,531,998	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	169,263	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 169,263	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. 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: 1/1/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,967	2,261	\$ 61,253	\$ 27.09	1
2	Assistant Director of Nursing	1,908	2,199	46,465	21.13	2
3	Registered Nurses	6,280	6,747	152,379	22.58	3
4	Licensed Practical Nurses	21,323	22,966	372,899	16.24	4
5	CNAs & Orderlies	84,357	88,936	798,695	8.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,205	5,526	54,111	9.79	10
11	Social Service Workers	1,756	2,181	35,328	16.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,182	24,671	216,529	8.78	15
16	Dishwashers					16
17	Maintenance Workers	3,118	3,392	47,222	13.92	17
18	Housekeepers	12,767	13,585	116,035	8.54	18
19	Laundry	9,036	9,494	72,821	7.67	19
20	Administrator	1,809	2,080	73,833	35.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,808	4,275	65,900	15.42	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	1,581	1,663	15,444	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	178,097	189,976	\$ 2,128,914 *	\$ 11.21	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	104	\$ 5,817	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	16	848	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,160	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	6	400	11,3	44
45	Social Service Consultant	6	400	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	36,866	10,3	47
48					48
49	TOTAL (lines 35 - 48)	132	\$ 55,091		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Healthcare Association \$3,090
- (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. \$ 8,689 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. \$ 60,080  
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? 35.16%  
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? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

MONTGOMERY NURSING & REHABILITATION CENTER  
RECLASSES  
ATTACHMENT TO SCHEDULE V  
12/31/2008

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS	20	(420)
NURSE AIDE TRAINING	13	420
To reclass expenses for CNA class test fees to proper line		
ADMINISTRATIVE	17	(2,894)
ACTIVITIES	11	435
MAINTENANCE	6	1,667
PROFESSIONAL SERVICES	19	792
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	4,800
NURSING & MEDICAL RECORDS	10	(4,800)
To reclass CNA trainer wages		
TRAVEL & SEMINAR	24	(85)
ADMINISTRATIVE	17	85
To reclass phone conferences to the proper line		
DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS	20	100
TRAVEL & SEMINAR	24	(100)
To reclass membership dues to the proper line		

Mongomery Nursing & Rehabilitation Center  
Attachment to Sch. XI, Part D  
December 31, 2008

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Detail of Line 79: Home Office Admin Vehicles

<u>Model, Make, &amp; 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>
2000 Taurus	2000	4,479	-	-	-	4	4,479
2001 Infiniti -Sold in 2008	2004	-	-	51	51	4	-
2008 Sonata	2008	3,196	-	466	466	4	466
2003 Infiniti	2008	3,294	-	69	69	4	69
2004 Infiniti-Sold in 2008	2006	-	-	669	669	4	-
2004 Jaguar	2007	5,840	-	1,460	1,460	4	2,433
		16,809	-	2,715	2,715		7,447

MONTGOMERY NURSING & REHABILITATION CENTER  
MISCELLANEOUS INCOME  
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28  
12/31/2008

Miscellaneous Income	\$	5
Lawsuit Reimbursement		832
Sysco Food Service Reimbursement		89
Seniorcise Program		980
	\$	<u>1,906</u>

**Montgomery Nursing and Rehabilitation Center**  
**Attachment to Sch. XVII**  
**December 31, 2008**

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	\$ 169,263
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>(119,502)</u>
SUBTOTAL	49,761
DEPRECIATION ADJUSTMENT	(60,169)
MISC. NON-DEDUCTIBLE EXPENSE	15,592
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>\$ 5,184</u></u>

MONTGOMERY NURSING & REHAB CENTER, INC.  
 TRAVEL AND SEMINAR SCHEDULE  
 ATTACHMENT TO SCHEDULE XIX PART G  
 12/31/2008

<u>Seminar Participant</u>	<u>Job Title</u>	<u>Dates</u>	<u>City</u>	<u>Title of Seminar</u>	<u>Sponsor</u>	<u>Cost</u>	<u>Seminar Lodging Travel/Meals</u>
Carla VonderHaar, Tammy Richmond,	Administrator, SS Director,	1/24/2008	Springfield, IL	Medicaid Audit	Illinois Health Care Association	450	103
Mindy Pearse, Mara Tomazzoli, Deb Schulte	RN, DON, ADON	10/23-10/24/08	Springfield, IL	2008 IAPA Conference	Illinois Activity Professionals Association	570	276
Cindi Paden & Pam Jones	Activity Director & Activity Asst.						
Leslie Brown	Business Office Manager	5/14/2008	Springfield, IL	Medicare in a SNF-Building the Basics	Illinois Health Care Association	100	58
Veronica Dobrinic & Sarah Laurent	CAN Instructors	3/17-3/21/08	Springfield, IL	CNA Instructor Course	Lincoln Land Community College	750	
Carla VonderHaar, Mara Tomazzoli	Administrator & DON	10/28-10/29/08	Springfield, IL	2008 Annual Convention & Trade Show	Illinois Nursing Home Administrator's Association	250	44
Cindi Paden	Activity Director	6/25-6/26/08	Springfield, IL	Activity Director's Course	Outcome Services	360	389
						2480	870
					Total Seminar Lodging/Travel/Meals	870	
					CPR Training	140	
					Other Travel Expenses <\$250	6368	
					Home Office Travel & Seminar	3888	
					Total Travel & Seminar, Line 24	13746	