

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,202	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)	46	16,836	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	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			3,617	3,617	8
9	SNF/PED					9
10	ICF	2,292	6,271	668	9,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,292	6,271	4,285	12,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 37.75%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1/28/1992

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 3,617

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2008 Fiscal Year: 6/30/2008

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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
	A. General Services										
1	Dietary	637,701	102,943	6,124	746,768		746,768	(413,655)	333,113		1
2	Food Purchase		461,603		461,603		461,603	(262,949)	198,654		2
3	Housekeeping	237,629	34,820	3,265	275,714		275,714	(201,081)	74,633		3
4	Laundry	45,441	14,217	1,276	60,934		60,934		60,934		4
5	Heat and Other Utilities			534,429	534,429		534,429	(389,330)	145,099		5
6	Maintenance	276,071	5,655	194,106	475,832		475,832	(321,319)	154,513		6
7	Other (specify):*										7
8	TOTAL General Services	1,196,842	619,238	739,200	2,555,280		2,555,280	(1,588,334)	966,946		8
	B. Health Care and Programs										
9	Medical Director			33,067	33,067		33,067		33,067		9
10	Nursing and Medical Records	1,037,341	58,346	28,046	1,123,733	378	1,124,111	(61)	1,124,050		10
10a	Therapy		1,722	302,927	304,649		304,649		304,649		10a
11	Activities	65,495	1,851	18,626	85,972		85,972		85,972		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation	45,683	145	10,258	56,086		56,086	(43,043)	13,043		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,148,519	62,064	392,924	1,603,507	378	1,603,885	(43,104)	1,560,781		16
	C. General Administration										
17	Administrative					138,680	138,680	(93,648)	45,032		17
18	Directors Fees										18
19	Professional Services			109,233	109,233	(8,191)	101,042	(67,820)	33,222		19
20	Dues, Fees, Subscriptions & Promotions			43,497	43,497	7,813	51,310	(34,649)	16,661		20
21	Clerical & General Office Expenses	605,625	38,279	191,137	835,041	(100,036)	735,005	(529,085)	205,920		21
22	Employee Benefits & Payroll Taxes			963,531	963,531	3,722	967,253	(411,894)	555,359		22
23	Inservice Training & Education			13,723	13,723		13,723	(9,267)	4,456		23
24	Travel and Seminar			15,254	15,254	(4,759)	10,495	(7,574)	2,921		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			271,841	271,841		271,841	(197,362)	74,479		26
27	Other (specify):* Unallowable Expenses			21,589	21,589		21,589	(21,589)			27
28	TOTAL General Administration	605,625	38,279	1,629,805	2,273,709	37,229	2,310,938	(1,372,888)	938,050		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,950,986	719,581	2,761,929	6,432,496	37,607	6,470,103	(3,004,326)	3,465,777		29

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

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

Facility Name & ID Number

Montgomery Place

#0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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			1,236,866	1,236,866		1,236,866	(942,987)	293,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,258,938	1,258,938		1,258,938	(914,013)	344,925			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,971	37,971		37,971	(25,641)	12,330			35
36	Other (specify):*											36
37	TOTAL Ownership			2,533,775	2,533,775		2,533,775	(1,882,641)	651,134			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,205	16,393	138,598		138,598		138,598			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,092	46,092		46,092		46,092			42
43	Other (specify):* ILU & Marketing	261,521	38,717	709,464	1,009,702	(37,607)	972,095	(972,095)				43
44	TOTAL Special Cost Centers	261,521	160,922	771,949	1,194,392	(37,607)	1,156,785	(972,095)	184,690			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,212,507	880,503	6,067,653	10,160,663		10,160,663	(5,859,062)	4,301,601			45

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

Facility Name & ID Number Montgomery Place

STATE OF ILLINOIS

0037515

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

Part V Supplement

Part V - Reclassifications

From Line To Line

Medical supplies	\$ 378	19	10
HUB service fee	7,813	19	20
Administrator wages	138,680	21	17
Admissions wages	37,607	43	21
Staff training manuals	1,037	24	21
Tuition reimbursement	1,250	24	22
Employee meals	2,472	24	22

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	(16,263)	2		4
5	Telephone, TV & Radio in Resident Rooms	(57,816)	21		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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,338)	27		18
19	Entertainment				19
20	Contributions	(635)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,331)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Supplemental Schedule</u>	(5,763,679)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,859,062)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (5,859,062)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Montgomery Place

ID# 0037515

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	ILU dietary	\$ (413,655)	1	1
2	ILU food purchases	(246,686)	2	2
3	ILU housekeeping	(197,768)	3	3
4	Revenue Offset - housekeeping	(3,313)	3	4
5	ILU heat & other utilities	(384,495)	5	5
6	Revenue Offset - miscellaneous services	(4,835)	5	6
7	ILU maintenance	(321,319)	6	7
8	Revenue Offset - medical records	(61)	10	8
9	ILU program transportation	(27,124)	14	9
10	Revenue Offset - transportation	(15,919)	14	10
11	ILU administrator	(93,648)	17	11
12	ILU professional services	(69,086)	19	12
13	Add FY08 legal expenses (see legal schedule)	16,578	19	13
14	Unallowable legal expenses (see legal schedule)	(15,312)	19	14
15	ILU dues, fees, subs	(34,649)	20	15
16	ILU clerical & office	(428,225)	21	16
17	Bank charges	(5,357)	21	17
18	Revenue Offset - admin fees	(36,000)	21	18
19	Music fund expenses	(335)	21	19
20	Library fund expenses	(1,202)	21	20
21	Garden fund expenses	(150)	21	21
22	ILU other employee benefits	(353,756)	22	22
23	ILU specific employee benefits	(55,579)	22	23
24	Marketing specific employee benefits	(2,559)	22	24
25	ILU inservice training	(9,267)	23	25
26	ILU travel & seminar	(6,075)	24	26
27	Unallowable travel	(1,499)	24	27
28	ILU insurance	(197,362)	26	28
29	Prior year items	(285)	27	29
30	ILU depreciation	(942,987)	30	30
31	ILU interest	(914,013)	32	31
32	ILU equipment rental	(25,641)	35	32
33	ILU specific expenses	(104,153)	43	33
34	Marketing specific expenses	(867,942)	43	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	(5,763,679)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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

	Operating Expenses	PAGES	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	(413,655)	0	0	0	0	0	0	0	0	0	0	(413,655)	1
2	Food Purchase	(262,949)	0	0	0	0	0	0	0	0	0	0	(262,949)	2
3	Housekeeping	(201,081)	0	0	0	0	0	0	0	0	0	0	(201,081)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(389,330)	0	0	0	0	0	0	0	0	0	0	(389,330)	5
6	Maintenance	(321,319)	0	0	0	0	0	0	0	0	0	0	(321,319)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,588,334)	0	(1,588,334)	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	(61)	0	0	0	0	0	0	0	0	0	0	(61)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	(43,043)	0	0	0	0	0	0	0	0	0	0	(43,043)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(43,104)	0	(43,104)	16									
	C. General Administration													
17	Administrative	(93,648)	0	0	0	0	0	0	0	0	0	0	(93,648)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(67,820)	0	0	0	0	0	0	0	0	0	0	(67,820)	19
20	Fees, Subscriptions & Promotions	(34,649)	0	0	0	0	0	0	0	0	0	0	(34,649)	20
21	Clerical & General Office Expenses	(529,085)	0	0	0	0	0	0	0	0	0	0	(529,085)	21
22	Employee Benefits & Payroll Taxes	(411,894)	0	0	0	0	0	0	0	0	0	0	(411,894)	22
23	Inservice Training & Education	(9,267)	0	0	0	0	0	0	0	0	0	0	(9,267)	23
24	Travel and Seminar	(7,574)	0	0	0	0	0	0	0	0	0	0	(7,574)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(197,362)	0	0	0	0	0	0	0	0	0	0	(197,362)	26
27	Other (specify):*	(21,589)	0	0	0	0	0	0	0	0	0	0	(21,589)	27
28	TOTAL General Administration	(1,372,888)	0	(1,372,888)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,004,326)	0	(3,004,326)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(942,987)	0	0	0	0	0	0	0	0	0	0	(942,987)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(914,013)	0	0	0	0	0	0	0	0	0	0	(914,013)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(25,641)	0	0	0	0	0	0	0	0	0	0	(25,641)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,882,641)	0	(1,882,641)	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):*	(972,095)	0	0	0	0	0	0	0	0	0	0	(972,095)	43
44	TOTAL Special Cost Centers	(972,095)	0	(972,095)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,859,062)	0	(5,859,062)	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
N/A				Hyde Park Home Care	Hyde Park	Home Health Agency

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	N/A	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2007Ending: 5/30/2008

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

Montgomery Place Independent Living

Street Address

5550 South Shore Drive

City / State / Zip Code

Chicago, IL 60637

Phone Number

(773) 753-4100

Fax Number

(773) 752-0056

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Meals	86,394	2	\$ 746,768	\$ 637,701	38,538	\$ 333,113	1
2	2	Food	Meals	86,394	2	445,340		38,538	198,654	2
3	3	Housekeeping	Square Feet	234,706	2	272,401	237,629	64,305	74,633	3
4	5	Utilities	Square Feet	234,706	2	529,594		64,305	145,099	4
5	6	Maintenance	Revenue	8,968,722	2	475,832	276,071	2,912,334	154,513	5
6	14	Program Transportation	Revenue	8,968,722	2	40,167	32,717	2,912,334	13,043	6
7	17	Administrative	Revenue	8,968,722	2	138,680	138,680	2,912,334	45,032	7
8	19	Professional Fees	Revenue	8,968,722	2	102,308		2,912,334	33,222	8
9	20	Dues and Subscriptions	Revenue	8,968,722	2	51,310		2,912,334	16,661	9
10	21	Clerical & General Office	Revenue	8,968,722	2	634,145	466,945	2,912,334	205,920	10
11	22	Employee Benefits	Salary	2,938,020	2	909,115		1,794,774	555,359	11
12	23	Inservice Training	Revenue	8,968,722	2	13,723		2,912,334	4,456	12
13	24	Travel & Seminar	Revenue	8,968,722	2	8,996		2,912,334	2,921	13
14	26	Insurance	Square Feet	234,706	2	271,841		64,305	74,479	14
15	30	Depreciation	Actual	0	2	1,236,866		293,879	293,879	15
16	32	Interest	Square Feet	234,706	2	1,258,938		64,305	344,925	16
17	35	Equipment Rental	Revenue	8,968,722	2	37,971		2,912,334	12,330	17
18	4	Laundry	Actual	60,934	1	60,934	45,441	60,934	60,934	18
19	9	Medical Director	Actual	33,067	1	33,067		33,067	33,067	19
20	10	Nursing/Medical Records	Actual	1,123,733	1	1,124,050	1,037,341	1,123,733	1,124,050	20
21	10a	Therapy	Actual	304,649	1	304,649		304,649	304,649	21
22	11	Activities	Actual	85,972	1	85,972	65,495	85,972	85,972	22
23	39	Ancillary	Actual	138,598	1	138,598		138,598	138,598	23
24	42	Provider Participation Fee	Actual	46,092	1	46,092		46,092	46,092	24
25	TOTALS					\$ 8,967,357	\$ 2,938,020		\$ 4,301,601	25

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Illinois Finance Authority		x	Revenue Bonds	N/A	11/20/06	\$ 40,850,000	\$ 36,940,000	05/2038	Variable	\$ 1,258,938	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 40,850,000	\$ 36,940,000			\$ 1,258,938	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 40,850,000	\$ 36,940,000			\$ 1,258,938	15								

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

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

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ _____ 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ _____ 2

3. Under or (over) accrual (line 2 minus line 1).

\$ _____ 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ _____ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ _____ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ _____ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ _____ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12

Not Applicable

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

NOTES:

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

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 Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Douglas J. Grimes, CPA

TELEPHONE (574) 236-8669 FAX #: (574) 236-8692

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>N/A</u>	<u>N/A</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
2.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
3.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
4.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
5.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
6.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
7.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
8.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
9.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
10.	<u>_____</u>	<u>_____</u>	<u>\$ _____</u>	<u>\$ _____</u>
		TOTALS	<u>\$ _____</u>	<u>\$ _____</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 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.

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning:

7/1/2007 Ending:

6/30/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
Montgomery Place Retirement Community, 170,401 square feet, 160 units

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

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

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

XI. OWNERSHIP COSTS:

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

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	93	1992	1992	\$ 5,735,741	\$	40	\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1997	20,111					
10	Various		1998	19,268					
11	Various		1999	40,652					
12	Various		2000	143,621					
13	Various		2001	117,397					
14	Various		2002	68,258					
15	Various		2003	95,898					
16	Various		2004	76,985					
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008**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	Sidewalk from east door	2005	\$ 1,140	\$	20	\$	\$	\$	37
38	Elevator	2005	1,280		20				38
39	Pwermat heating valve	2005	485		20				39
40	Auto condensat drain on air system	2005	1,025		20				40
41	Expansion valve on a/c	2005	560		20				41
42	Boiler pump motor	2005	802		20				42
43	Replacement parts - fire alarm system	2005	1,766		20				43
44	Elevator keypads	2006	3,068		20				44
45	Elevator work	2006	6,221		20				45
46	Elevator shaft smoke detectors	2006	3,433		20				46
47	Elevator cab design fees	2006	482		20				47
48	New piping in kitchen	2006	1,575		20				48
49	Door systems	2007	395		20				49
50	Door systems	2007	294		20				50
51	Fan coil motors	2007	178		20				51
52	Water ball valves	2007	7,023		20				52
53	Gas valve	2007	433		20				53
54	Motor, coupling, freeze stat	2007	627		20				54
55	Air flow fan	2007	220		20				55
56	Door gasket for cooler	2007	295		20				56
57	Riser leak repair	2007	233		20				57
58	Repair chiller	2007	1,502		20				58
59	Elevator	2007	877		20				59
60	Elevator	2008	3,481		20				60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Total nursing facility depreciation expense			293,879		293,879		1,926,018	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,355,326	\$ 293,879		\$ 293,879	\$	\$ 1,926,018	70

**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	\$ 725,384	\$	\$	\$	10	\$	71
72	Current Year Purchases	\$ 390,553				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,115,937	\$	\$	\$		\$	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	1999 Plymouth Voyager	2004	\$ 1,382	\$	\$	\$	5	\$	76
77	Facility	2005 Glaval Universal Bus	2004	12,922				5		77
78	Facility	Auto	2007	4,110				5		78
79										79
80	TOTALS			\$ 18,414	\$	\$	\$		\$	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)	\$ 8,381,102	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 293,879	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 293,879	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,926,018	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living Alloc	\$ 25,434,149	\$ 942,987	\$ 8,739,584	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 25,434,149	\$ 942,987	\$ 8,739,584	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 12,146,815	92
93			93
94			94
95		\$ 12,146,815	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: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 37,971 Description: Copiers \$21,562; Postage Meter \$4,334; Miscellaneous as-needed \$12,075

(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>N/A</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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a Col. 2 & 3	hrs		\$	6,792	\$ 160,491	\$ 826	6,792	\$ 161,317						1
2	Licensed Speech and Language Development Therapist	10a Col. 2 & 3	hrs			143	4,348	0	143	4,348						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a Col. 2 & 3	hrs			5,971	138,088	896	5,971	138,984						4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL				\$	12,906	\$ 302,927	\$ 1,722	12,906	\$ 304,649						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.

Facility Name & ID Number **Montgomery Place**# **0037515**Report Period Beginning: **7/1/2007**Ending: **6/30/2008****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2008**

(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	\$ 1,017,670	\$	1
2	Cash-Patient Deposits	99,069		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (49,800))	292,648		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,065,308		5
6	Prepaid Insurance	101,981		6
7	Other Prepaid Expenses	59,818		7
8	Accounts Receivable (owners or related parties)	70,265		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,706,759	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,913,400		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	26,005,136		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,556,502		16
17	Accumulated Depreciation (book methods)	(15,825,198)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	12,961,316		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	13,604,514		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 47,469,282	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 51,176,041	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 442,719	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	656,830		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,277		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	288,721		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to affiliate</u>	2,876,326		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,492,873	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	36,940,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Bond premium</u>	690,764		43
44	<u>See Supplemental Schedule</u>	13,616,426		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 51,247,190	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 55,740,063	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,564,022)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 51,176,041	\$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schule

Line 28 - Other Assets		Line 44 - Other Long-term Liabilities	
<u>Description</u>	<u>Amount</u>	<u>Description</u>	<u>Amount</u>
Capitalized interest	\$ 413,288	Resident deposits, refundable	\$12,067,092
Construction in progress	11,733,527	Independent living security deposits	414,021
Bond financing costs, net	1,393,914	Resident deposits, non-refundable	865,313
Capitalized marketing costs, net	63,785	Securities donation liability	270,000
	\$ 13,604,514		\$13,616,426

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,386,613)	1
2	Restatements (describe):		2
3	Prior year adjustment	(3,886)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,390,499)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(173,523)	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)	\$ (173,523)	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)	\$ (4,564,022)	24 *

* This must agree with page 17, line 47.

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	\$ 2,912,334	1
2	Discounts and Allowances for all Levels	(769,497)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,142,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	708,562	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 708,562	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,988	13
14	Non-Patient Meals	16,263	14
15	Telephone, Television and Radio	101,293	15
16	Rental of Facility Space	145,215	16
17	Sale of Drugs	116,848	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,300	19
20	Radiology and X-Ray	4,395	20
21	Other Medical Services	171,312	21
22	Laundry	8,138	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 589,752	23
	D. Non-Operating Revenue		
24	Contributions	1,375	24
25	Interest and Other Investment Income***	322,604	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 323,979	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	6,222,010	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,222,010	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,987,140	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,555,280	31
32	Health Care	1,603,507	32
33	General Administration	2,273,709	33
	B. Capital Expense		
34	Ownership	2,533,775	34
	C. Ancillary Expense		
35	Special Cost Centers	1,148,300	35
36	Provider Participation Fee	46,092	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,160,663	40
41	Income before Income Taxes (line 30 minus line 40)**	(173,523)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (173,523)	43

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

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

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

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

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

<u>Description</u>	<u>Amount</u>
Independent Living	\$ 6,056,388
Miscellaneous Income	64,455
Medical Records	61
Vending	917
Various Funds (Employee, Music, Library, etc.)	6,671
Administration Fee Revenue	36,000
Additional Resident Meals	33,451
Housekeeping Services	3,313
Miscellaneous Services	4,835
Transportation	15,919
	<u>\$ 6,222,010</u>

Line 25 Interest and Other Investment Income

Income reported on this line includes changes to the market value of investments and restricted funds. These amounts have not been offset against interest expense reported on Schedule V, line 32.

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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	1,672	1,685	\$ 89,572	\$ 53.16	1
2	Assistant Director of Nursing	1,792	1,785	60,670	33.99	2
3	Registered Nurses	3,246	3,240	97,450	30.08	3
4	Licensed Practical Nurses	19,396	18,255	393,830	21.57	4
5	CNAs & Orderlies	38,156	36,849	361,198	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,432	1,512	28,661	18.96	9
10	Activity Assistants	4,173	4,297	36,834	8.57	10
11	Social Service Workers					11
12	Dietician	2,144	2,333	43,797	18.77	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,689	31,908	375,208	11.76	15
16	Dishwashers	13,901	21,711	198,210	9.13	16
17	Maintenance Workers	6,240	8,823	132,871	15.06	17
18	Housekeepers	12,838	11,357	117,580	10.35	18
19	Laundry	4,390	4,006	45,441	11.34	19
20	Administrator	1,776	2,175	138,680	63.76	20
21	Assistant Administrator					21
22	Other Administrative	1,792	1,157	37,607	32.50	22
23	Office Manager	1,857	2,080	93,942	45.16	23
24	Clerical	6,436	32,832	391,701	11.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,234	2,220	34,622	15.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See supplemental</u>	33,953	37,095	534,633	14.41	33
34	TOTAL (lines 1 - 33)	177,117	225,320	\$ 3,212,507 *	\$ 14.26	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	\$ 6,124	A1.3	35
36	Medical Director	33,067	B9.3	36
37	Medical Records Consultant			37
38	Nurse Consultant	604	B10.3	38
39	Pharmacist Consultant	1,317	B10.3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	1,816	B11.3	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 42,928		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

PG20 Supplement

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 7/1/2007

Ending:

6/30/2008

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - LINE 33

		1	2**	3	4
	Description	# of Hrs.	# of Hrs.	Reporting Period	Average
		Actually	Paid and	Total Salaries,	Hourly
		Worked	Accrued	Wages	Wage
33 A	Security	\$ 9,444	10,296	\$ 144,867	\$ 14.07
33 B	Transportation	2,984	3,165	45,803	15.35
33 C	Marketing	7,232	8,056	166,480	20.67
33 D	Environmental Services - IL	11,555	12,366	120,049	9.71
33 E	Activity Director - IL	<u>2,738</u>	<u>3,212</u>	<u>57,434</u>	<u>17.88</u>
	Total Line 33	<u>\$ 33,953</u>	<u>37,095</u>	<u>\$ 534,633</u>	<u>\$ 14.41</u>

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2007 Ending:

6/30/2008

Page 21, C. Profession Fee Services - Detail of legal invoices

Inv #	Date	GL Acct.	Payee/Vendor	Amount	Comments	Unallowable Cost
1319269	07/13/07	5446-10-201	Duane Morris	\$ 93	General facility matters	\$ -
1326378	08/16/07	5446-10-201	Duane Morris	111	Employment matters	-
1333092	09/17/07	5446-10-201	Duane Morris	558	General facility matters	-
1333093	09/17/07	5446-10-201	Duane Morris	694	IRS former employee matters	694
1348597	11/15/07	5446-10-201	Duane Morris	607	General facility matters	-
1348600	11/15/07	5446-10-201	Duane Morris	1,443	Employment matters	-
1354238	12/10/07	5446-10-201	Duane Morris	372	General facility matters	-
1354239	12/10/07	5446-10-201	Duane Morris	5,393	Employment matters	-
1361805	01/15/08	5446-10-201	Duane Morris	1,367	General facility matters	-
1361806	01/15/05	5446-10-201	Duane Morris	881	Employment matters	-
1368237	02/07/08	5446-10-201	Duane Morris	3,456	General facility matters	-
1368238	02/07/08	5446-10-201	Duane Morris	891	Employment matters	-
1368239	02/07/08	5446-10-201	Duane Morris	39	Collective Bargaining Agreement - employees	-
1377535	03/14/08	5446-10-201	Duane Morris	1,602	General facility matters	-
1384375	04/16/08	5446-10-201	Duane Morris	1,049	General facility matters	-
1384376	04/16/08	5446-10-201	Duane Morris	351	Collective Bargaining Agreement - employees	-
1393718	05/15/08	5446-10-201	Duane Morris	122	General facility matters	-
1393719	05/15/08	5446-10-201	Duane Morris	8,298	Collective Bargaining Agreement - employees	-
1394893	05/21/08	5446-10-201	Duane Morris	59	Employment matters	-
1401505	06/19/08	5446-10-201	Duane Morris	195	Employment matters	-
1401506	06/19/08	5446-10-201	Duane Morris	2,613	Collective Bargaining Agreement - employees	-
8155248	07/31/07	5446-10-201	Ungaretti & Harris	229	Assisted/Independent Living matters	229
8156834	09/30/07	5446-10-201	Ungaretti & Harris	609	Assisted/Independent Living matters	609
8158100	10/31/07	5446-10-201	Ungaretti & Harris	2,031	Assisted/Independent Living matters	2,031
8158967	11/30/07	5446-10-201	Ungaretti & Harris	4,550	Assisted/Independent Living matters	4,550
8159700	12/31/07	5446-10-201	Ungaretti & Harris	1,643	Assisted/Independent Living matters	1,643
8161275	02/29/08	5446-10-201	Ungaretti & Harris	1,855	Assisted/Independent Living matters	1,855
8164848	06/30/08	5446-10-201	Ungaretti & Harris	257	Assisted/Independent Living matters	257
5006	10/02/07	5446-10-201	McParland & Phillips, LLC	180	General facility matters	180
5118	11/01/07	5446-10-201	McParland & Phillips, LLC	360	General facility matters	-
1255610	05/08/08	5446-10-201	Schiff Hardin LLP	153	Modification to cell tower agreement	153
1263154	06/10/08	5446-10-201	Schiff Hardin LLP	3,111	Sprint/Nextel license agreement	3,111
111029	08/31/07	5446-10-201	Franczek Sullivan P.C.	4,100	General facility matters - employees	-
111972	10/31/07	5446-10-201	Franczek Sullivan P.C.	164	General facility matters - employees	-
112426	11/26/07	5446-10-201	Franczek Sullivan P.C.	1,655	General facility matters - employees	-
112915	12/27/07	5446-10-201	Franczek Sullivan P.C.	1,037	General facility matters - employees	-
113462	01/31/08	5446-10-201	Franczek Sullivan P.C.	1,366	General facility matters - employees	-
113906	02/29/08	5446-10-201	Franczek Sullivan P.C.	158	General facility matters - employees	-
114425	03/31/08	5446-10-201	Franczek Sullivan P.C.	1,180	General facility matters - employees	-
114936	04/29/08	5446-10-201	Franczek Sullivan P.C.	320	General facility matters - employees	-
115407	05/31/08	5446-10-201	Franczek Sullivan P.C.	74	General facility matters - employees	-
				\$ 55,224		\$ 15,312

Note: Some fiscal year 2008 legal invoices, received in fiscal year 2008, were not expensed until fiscal year 2009. These invoices have been added to the cost report by an adjustment in Part VI.

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 7/1/2007Ending: 6/30/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,167 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. \$ 46,092
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (Ind. Living) 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,178
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe Horwath LLP 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. Final audit report not available as of 1
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees