



Facility Name & ID Number Montgomery Terrace

# 0047001 Report Period Beginning: 01/01/2008 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	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,080</u>			<u>5,080</u>
14	TOTALS	<u>5,080</u>			<u>5,080</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.75%

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

524 (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 March 11, 1987

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

YES  Date March 11, 1987 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12-31-08 Fiscal Year: N/A

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

Facility Name & ID Number Montgomery Terrace # 0047001 Report Period Beginning: 01/01/2008 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	22,441		1,010	23,451		23,451		23,451		1
2	Food Purchase		42,131		42,131		42,131	(831)	41,300		2
3	Housekeeping	5,547	351		5,898		5,898		5,898		3
4	Laundry		1,114		1,114		1,114		1,114		4
5	Heat and Other Utilities			16,824	16,824		16,824	204	17,028		5
6	Maintenance	6,921	329	6,796	14,046		14,046		14,046		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>34,909</b>	<b>43,925</b>	<b>24,630</b>	<b>103,464</b>		<b>103,464</b>	<b>(627)</b>	<b>102,837</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	137,445	2,422	18,058	157,925	(2,418)	155,507		155,507		10
10a	Therapy			90	90		90		90		10a
11	Activities	14,608	1,975	1,200	17,783		17,783		17,783		11
12	Social Services			149	149		149		149		12
13	CNA Training			195	195	2,418	2,613		2,613		13
14	Program Transportation			4,916	4,916		4,916		4,916		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>152,053</b>	<b>4,397</b>	<b>29,408</b>	<b>185,858</b>		<b>185,858</b>		<b>185,858</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	28,448			28,448		28,448		28,448		17
18	Directors Fees										18
19	Professional Services			4,945	4,945		4,945		4,945		19
20	Dues, Fees, Subscriptions & Promotions			881	881		881		881		20
21	Clerical & General Office Expenses	20,029	458	24,951	45,438		45,438	(17,091)	28,347		21
22	Employee Benefits & Payroll Taxes			28,003	28,003		28,003	3,885	31,888		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,193	1,193		1,193		1,193		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,646	6,646		6,646		6,646		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>48,477</b>	<b>458</b>	<b>66,619</b>	<b>115,554</b>		<b>115,554</b>	<b>(13,206)</b>	<b>102,348</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>235,439</b>	<b>48,780</b>	<b>120,657</b>	<b>404,876</b>		<b>404,876</b>	<b>(13,833)</b>	<b>391,043</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.

## 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
	<b>D. Ownership</b>										
30	Depreciation			1,047	1,047	1,047	19,107	20,154			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			5	5	5	79	84			32
33	Real Estate Taxes			8,986	8,986	8,986		8,986			33
34	Rent-Facility & Grounds			50,400	50,400	50,400		50,400			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>State income tax</b>			1,095	1,095	1,095	(1,095)				36
37	<b>TOTAL Ownership</b>			61,533	61,533	61,533	18,091	79,624			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			31,974	31,974	31,974		31,974			42
43	Other (specify):* <b>Personal supplies</b>			1,228	1,228	1,228	(1,228)				43
44	<b>TOTAL Special Cost Centers</b>			33,202	33,202	33,202	(1,228)	31,974			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	235,439	48,780	215,392	499,611	499,611	3,030	502,641			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	4,624	30		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	(831)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,095)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,278)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 1,420		\$	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)	1,610		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,610		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 3,030		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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Terrace

ID# 0047001

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Personal supplies	\$ (1,228)	43	1
2	Gifts	(50)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,278)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Terrace# 0047001

Report Period Beginning:

01/01/2008

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	(831)	0	0	0	0	0	0	0	0	0	0	(831)	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	204	0	0	0	0	0	0	0	0	0	204	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(831)</b>	<b>204</b>	<b>0</b>	<b>(627)</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	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	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>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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(50)	(17,041)	0	0	0	0	0	0	0	0	0	(17,091)	21
22	Employee Benefits & Payroll Taxes	0	3,885	0	0	0	0	0	0	0	0	0	3,885	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(50)</b>	<b>(13,156)</b>	<b>0</b>	<b>(13,206)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(881)</b>	<b>(12,952)</b>	<b>0</b>	<b>(13,833)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning:

01/01/2008 Ending:

Summary B

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	4,624	14,483	0	0	0	0	0	0	0	0	0	19,107	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	79	0	0	0	0	0	0	0	0	0	79	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	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	36
37	<b>TOTAL Ownership</b>	<b>3,529</b>	<b>14,562</b>	<b>0</b>	<b>18,091</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):*	(1,228)	0	0	0	0	0	0	0	0	0	0	(1,228)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,228)</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>(1,228)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>1,420</b>	<b>1,610</b>	<b>0</b>	<b>3,030</b>	<b>45</b>								

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
Angela Barr-Cornell	100%	See Attached	Oviedo, FL			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Central Office	\$ 18,624	Angela Barr-Cornell	100.00%	\$	\$ (18,624)	1
2	V	5 Utilities				204	204	2
3	V	21 Office expense				1,583	1,583	3
4	V	22 Employee Insurance				3,885	3,885	4
5	V	30 Depreciation expense				14,483	14,483	5
6	V	32 Interest expense				79	79	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 18,624			\$ 20,234	\$ * 1,610	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace # 0047001 Report Period Beginning: 01/01/2008 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	Angela Barr-Cornell	Owner	Admin-Mgmt	100.00	71,009	5	70.00	Admin-Mgmt	\$ 18,135	17-1	1
2	Angela Barr-Cornell	Owner	Admin-Clerical	100.00	28,083	3	30.00	Admin-Clerical	7,772	21-1	2
3	Jason Cornell	Owner	Maintenance		2,080						3
4	Cara Ebbeler	Owner	Consultant		4,800			Consultant	1,200	11-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,107		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 Terrace

# 0047001

Report Period Beginning: 01/01/2008

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

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

Name of Related Organization Angela Barr-Cornell  
 Street Address 80 Ellington Place  
 City / State / Zip Code Oviedo, FL 32765  
 Phone Number ( )  
 Fax Number ( )

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Hickory Point Bank		X	2005 Chevy Van	\$525.00	10/17/05	\$ 14,792	\$	04/16/08	4.9000	\$ 5	1								
2												2								
3	Central Office										79	3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$525.00		\$ 14,792	\$			\$ 84	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 14,792	\$			\$ 84	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 7,721	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.)		\$ 8,307	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 586	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 8,400	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 8,986	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	6,374	8
	2004	7,239	9
	2005	7,364	10
	2006	7,722	11
	2007	8,307	12
	<b>FOR BHF USE ONLY</b>		
	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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Terrace COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0047001

CONTACT PERSON REGARDING THIS REPORT Janet Byers

TELEPHONE ( 217 ) 422-4725 FAX #: ( )

**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>10-002-066-00</u>	<u>Nursing Facility</u>	\$ <u>8,307.00</u>	\$ <u>8,307.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>8,307.00</u>	\$ <u>8,307.00</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.

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,030 B. General Construction Type: Exterior Brick/Vinyl Frame Wood/Gypsum Board 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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2		N/A			2
3	TOTALS	#VALUE!		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Montgomery Terrace

# 0047001

Report Period Beginning:

01/01/2008

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Sprinkler Changes		1987	575		10			575	9
10		Storage Shed		1987	509		10			509	10
11		Fire Alarm		1989	810		10			810	11
12		Landscaping		1990	850		10			850	12
13		Carpet		1992	3,597		10			3,597	13
14		Gillen Properties Painting		1993	500		10			500	14
15		Wallpaper		1995	372		10			372	15
16		Flooring		1996	818		10			818	16
17		Air Conditioner		1996	1,396		10			1,396	17
18		Carpeting/Flooring		1997	2,731	162	20	137	(25)	2,166	18
19		Window Air Conditioner		1998	1,647		10	121	121	1,647	19
20		Deck		2001	4,735	279	20	237	(42)	2,638	20
21		Ceramic Tiling		2003	3,963	173	20	198	25	2,407	21
22		Resurface Parking Lot		2003	1,995	62	20	100	38	1,436	22
23		Bathroom Improvements		2004	1,356		15	90	90	1,356	23
24		Interior Painting		2005	1,895	146	20	95	(51)	583	24
25		Bathroom Floor		2005	1,085	84	20	54	(30)	334	25
26		Water Temp Regulator		2005	1,441	111	20	72	(39)	443	26
27		Sprinkler System Repairs		2006	1,210		10	121	121	1,210	27
28		Automatic Door Closure		2006	1,108		10	111	111	1,108	28
29		Sewer Work		2007	4,248		20	212	212	4,248	29
30		Roof		2008	9,310	14	27.5	28	14	14	30
31		Repave Driveway		2008	1,650	7	27.5	5	(2)	7	31
32											32
33											33
34		Central Office						14,483	14,483		34
35											35
36											36

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Montgomery Terrace**

# **0047001**

Report Period Beginning:

**01/01/2008**

Ending:

**12/31/2008**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		47,801	1,038		16,064	15,026	29,024	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Terrace # 0047001 Report Period Beginning: 01/01/2008 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	\$ 212	\$ 9	\$ 21	\$ 12		\$ 212	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	18,723		1,111	1,111		18,723	73
74								74
75	TOTALS	\$ 18,935	\$ 9	\$ 1,132	\$ 1,123		\$ 18,935	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	Transportation	2005 Chevy Van	2005	\$ 14,792	\$	\$ 2,958	\$ 2,958	5	\$ 14,792	76
77										77
78										78
79										79
80	TOTALS			\$ 14,792	\$	\$ 2,958	\$ 2,958		\$ 14,792	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)	\$ 81,528	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,047	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,154	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,107	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 62,751	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		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Flora Bank & Trust

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:	<u>1987</u>	<u>16</u>	<u>01/12/87</u>	\$ <u>50,400</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>16</b>		\$ <b>50,400</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 03/06/07

Ending 03/06/12

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2009</u>	\$ <u>50,400</u>
13.	<u>12/31/2010</u>	\$ <u>50,400</u>
14.	<u>12/31/2011</u>	\$ <u>50,400</u>

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: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</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		195		195
3	Classroom Wages (a)		775		775
4	Clinical Wages (b)		1,240		1,240
5	In-House Trainer Wages (c)		403		403
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,613	\$	\$ 2,613
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,613		

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)	
<b>TOTAL TRAINED</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

Facility Name & ID Number Montgomery Terrace# 0047001 Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits	N/A					#VALUE!	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			\$		\$	\$		\$	#VALUE!

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 Terrace# 0047001Report Period Beginning: 01/01/2008

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	\$ 112,880	\$ 763,776	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	176,586	488,341	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,785	38,136	7
8	Accounts Receivable (owners or related parties)		230,961	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 297,251	\$ 1,521,214	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	47,801	307,781	15
16	Equipment, at Historical Cost	33,727	238,369	16
17	Accumulated Depreciation (book methods)	(62,751)	(472,986)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 18,777	\$ 73,164	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 316,028	\$ 1,594,378	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 15,482	\$ 80,157	26
27	Officer's Accounts Payable	500	500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		4,364	29
30	Accrued Salaries Payable	8,921	40,849	30
31	Accrued Taxes Payable (excluding real estate taxes)	230	4,864	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,400	33,800	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,095	9,956	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Workshop</u>		8,944	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 34,628	\$ 183,434	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		7,393	39
40	Mortgage Payable			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>	\$	\$ 7,393	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 34,628	\$ 190,827	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 281,400	\$ 1,403,551	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 316,028	\$ 1,594,378	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 148,305	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 148,305	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	88,295	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	44,800	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)	\$ 133,095	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)	\$ 281,400	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace# 0047001Report Period Beginning: 01/01/2008Ending: 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	\$ 587,882	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 587,882	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 24	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 587,906	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	103,464	31
32	Health Care	185,858	32
33	General Administration	115,554	33
<b>B. Capital Expense</b>			
34	Ownership	61,533	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,228	35
36	Provider Participation Fee	31,974	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 499,611	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	88,295	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 88,295	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 Terrace

# 0047001

Report Period Beginning: 01/01/2008

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	
2	Assistant Director of Nursing				2	
3	Registered Nurses	288	291	10,445	35.89	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	10,712	11,451	102,479	8.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,674	1,674	14,608	8.73	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,540	2,540	22,441	8.84	15
16	Dishwashers					16
17	Maintenance Workers	384	416	6,921	16.64	17
18	Housekeepers	631	631	5,547	8.79	18
19	Laundry					19
20	Administrator	588	609	28,448	46.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	546	572	20,029	35.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,536	1,664	24,521	14.74	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,899	19,848	\$ 235,439 *	\$ 11.86	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	19	\$ 1,010	1-3	35
36	Medical Director	Mo. Fee	4,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	572	13,905	10-3	38
39	Pharmacist Consultant	Mo. Fee	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	90	10A-3	43
44	Activity Consultant	Mo. Fee	1,200	11-3	44
45	Social Service Consultant	4	149	12-3	45
46	Other(specify) <u>Dental</u>	Per visit	1,903	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	597	\$ 24,857		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		N/A	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Terrace

# 0047001

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Anna Brackenbush	Adm.	0	\$ 5,836	Workers' Compensation Insurance	\$ 5,510	IDPH License Fee	\$		
Pam Rosenkranz	Adm.	0	4,477	Unemployment Compensation Insurance	3,198	Advertising: Employee Recruitment	322		
Angela Barr-Cornell	Adm.	100	18,135	FICA Taxes	17,873	Health Care Worker Background Check			
				Employee Health Insurance	3,885	(Indicate # of checks performed <u>5</u> )	80		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	32		
				Simple IRA	1,422	Licenses & Fees	447		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 28,448						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel	990	
							Seminar Expense		
							Food Service Sanitation	59	
							CPR	70	
							Career Track Seminar	74	
							Entertainment Expense		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)								\$ 881	
C. Professional Services									
Vendor/Payee	Type	Amount							
Larsson, Woodyard & Henson	Accounting	\$ 4,093							
Anderson Law Office	Legal	852							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 4,945						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

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

\*\*See instructions.

Facility Name & ID Number Montgomery Terrace

Report Period Beginning: 01/01/2008 Ending:

**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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8	N/A												
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,974  
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? Yes 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? N/A
- (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. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? No  
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? \_\_\_\_\_  
**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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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