

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1/24/08

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	88	Intermediate (ICF)	88	32,120	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	628	497	3,669	4,794	8	
9	SNF/PED					9	
10	ICF	17,053	13,612		30,665	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	17,681	14,109	3,669	35,459	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.32%

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 04/01/1994

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

YES Date 04/01/1994 NO

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

YES NO If YES, enter number of beds certified 20 and days of care provided 3,669

Medicare Intermediary Pinnacle Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	228,410	14,566	5,988	248,964		248,964		248,964		1
2	Food Purchase		184,250		184,250		184,250		184,250		2
3	Housekeeping	119,402	17,349		136,751		136,751		136,751		3
4	Laundry	78,274	9,304		87,578		87,578		87,578		4
5	Heat and Other Utilities			116,095	116,095		116,095		116,095		5
6	Maintenance	48,249	7,771	35,573	91,593	1,664	93,257	645	93,902		6
7	Other (specify):* Med. Waste/Sanitation			4,526	4,526		4,526		4,526		7
8	TOTAL General Services	474,335	233,240	162,182	869,757	1,664	871,421	645	872,066		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,515,491	100,190	46,970	1,662,651	(7,200)	1,655,451		1,655,451		10
10a	Therapy		5,661	474,425	480,086		480,086	(16,654)	463,432		10a
11	Activities	51,655	6,260	520	58,435	469	58,904		58,904		11
12	Social Services	35,358	247	520	36,125		36,125		36,125		12
13	CNA Training			2,702	2,702	7,152	9,854		9,854		13
14	Program Transportation		4,826		4,826		4,826		4,826		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,602,504	117,184	534,737	2,254,425	421	2,254,846	(16,654)	2,238,192		16
	C. General Administration										
17	Administrative	77,375	19,040	243,970	340,385	(6,158)	334,227	(109,999)	224,228		17
18	Directors Fees										18
19	Professional Services			65,128	65,128	4,025	69,153	(48,014)	21,139		19
20	Dues, Fees, Subscriptions & Promotions			55,650	55,650	48	55,698	(33,123)	22,575		20
21	Clerical & General Office Expenses	61,821	17,561	59,601	138,983		138,983	33,201	172,184		21
22	Employee Benefits & Payroll Taxes			340,658	340,658		340,658	10,784	351,442		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,982	11,982		11,982	826	12,808		24
25	Other Admin. Staff Transportation							951	951		25
26	Insurance-Prop.Liab.Malpractice			52,845	52,845		52,845	1,333	54,178		26
27	Other (specify):*										27
28	TOTAL General Administration	139,196	36,601	829,834	1,005,631	(2,085)	1,003,546	(144,041)	859,505		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,216,035	387,025	1,526,753	4,129,813		4,129,813	(160,050)	3,969,763		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			137,208	137,208		137,208	4,221	141,429			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			151,659	151,659		151,659	(25,187)	126,472			32
33	Real Estate Taxes			51,841	51,841		51,841		51,841			33
34	Rent-Facility & Grounds							11,060	11,060			34
35	Rent-Equipment & Vehicles			4,595	4,595		4,595	1,998	6,593			35
36	Other (specify):* Mortgage Ins.			11,777	11,777		11,777		11,777			36
37	TOTAL Ownership			357,080	357,080		357,080	(7,908)	349,172			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,929	1,929		1,929		1,929			38
39	Ancillary Service Centers		131,344	26,519	157,863		157,863		157,863			39
40	Barber and Beauty Shops		1,157		1,157		1,157		1,157			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,501	88,673	221,174		221,174		221,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,216,035	519,526	1,972,506	4,708,067		4,708,067	(167,958)	4,540,109			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,624)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,263)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,338)	24		19
20	Contributions	(1)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(228)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,849)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,280)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (45,583)		\$	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)	(122,375)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (122,375)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (167,958)		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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Eliminate PAC dues , including Lobbying portion	\$ (2,275)	20	1
2	Add 2009 IDPH license paid in 2008	995	20	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	Total	(1,280)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	645	0	0	0	0	0	0	0	0	0	645	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	645	0	0	0	0	0	0	0	0	0	645	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	(16,654)	0	0	0	0	0	0	0	0	(16,654)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	(16,654)	0	(16,654)	16							
	C. General Administration													
17	Administrative	0	67,447	(177,446)	0	0	0	0	0	0	0	0	(109,999)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(228)	3,754	(51,540)	0	0	0	0	0	0	0	0	(48,014)	19
20	Fees, Subscriptions & Promotions	(35,393)	2,270	0	0	0	0	0	0	0	0	0	(33,123)	20
21	Clerical & General Office Expenses	0	33,201	0	0	0	0	0	0	0	0	0	33,201	21
22	Employee Benefits & Payroll Taxes	0	10,784	0	0	0	0	0	0	0	0	0	10,784	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,338)	4,164	0	0	0	0	0	0	0	0	0	826	24
25	Other Admin. Staff Transportation	0	951	0	0	0	0	0	0	0	0	0	951	25
26	Insurance-Prop.Liab.Malpractice	0	1,333	0	0	0	0	0	0	0	0	0	1,333	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(38,959)	123,904	(228,986)	0	(144,041)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,959)	124,549	(245,640)	0	(160,050)	29							

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	4,221	0	0	0	0	0	0	0	0	0	4,221	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,624)	9	(18,572)	0	0	0	0	0	0	0	0	(25,187)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,060	0	0	0	0	0	0	0	0	0	11,060	34
35	Rent-Equipment & Vehicles	0	1,998	0	0	0	0	0	0	0	0	0	1,998	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,624)	17,288	(18,572)	0	(7,908)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(45,583)	141,837	(264,212)	0	0	0	0	0	0	0	0	(167,958)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	6 See Schedule VIII	\$	Wellington Management Company	60.00%	\$ 645	\$	645	1
2	V	17 See Schedule VIII		Wellington Management Company	60.00%	67,447		67,447	2
3	V	19 See Schedule VIII		Wellington Management Company	60.00%	3,754		3,754	3
4	V	20 See Schedule VIII		Wellington Management Company	60.00%	2,270		2,270	4
5	V	21 See Schedule VIII		Wellington Management Company	60.00%	33,201		33,201	5
6	V	22 See Schedule VIII		Wellington Management Company	60.00%	10,784		10,784	6
7	V	24 See Schedule VIII		Wellington Management Company	60.00%	4,164		4,164	7
8	V	25 See Schedule VIII		Wellington Management Company	60.00%	951		951	8
9	V	26 See Schedule VIII		Wellington Management Company	60.00%	1,333		1,333	9
10	V	30 See Schedule VIII		Wellington Management Company	60.00%	4,221		4,221	10
11	V	32 See Schedule VIII		Wellington Management Company	60.00%	9		9	11
12	V	34 See Schedule VIII		Wellington Management Company	60.00%	11,060		11,060	12
13	V	35 See Schedule VIII		Wellington Management Company	60.00%	1,998		1,998	13
14	Total		\$			\$ 141,837	\$ *	141,837	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$ 27,825	Wellington Management Company	60.00%	\$ 27,825	\$
16	V	17 Management Fees	175,658	Wellington Management Company	60.00%		(175,658)
17	V	17 Management Fees	68,312	Health Care Financial, LLC	40.00%	66,524	(1,788)
18	V	19 Professional Services	51,540	C.J. Schlosser & Company, LLC	40.00%		(51,540)
19	V	10a Therapy Services	474,425	NW Rehab, LLC	100.00%	457,771	(16,654)
20	V	32 Interest	10,972	John H. Rothert	60.00%		(10,972)
21	V	32 Interest	3,800	J. Terry Dooling	20.00%		(3,800)
22	V	32 Interest	3,800	David L. Kamler	20.00%		(3,800)
23	V	21 Clerical	16,690	Wellington Management Company	60.00%	16,690	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 833,022			\$ 568,810	\$ * (264,212)

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cent # 0039347 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	292,553	7.49	18.74	Salary	\$ 67,447	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 67,447		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Wellington Management Corporation
 Street Address 707 Spirit 40 Park Drive
 City / State / Zip Code Chesterfield, MO 63005
 Phone Number (636) 537-8447
 Fax Number (636) 537-8446

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Accumulated Costs	21,275,824	6	\$ 3,443	\$ 3,986,084	\$ 645	1	
2	17	Administrative	Accumulated Costs	21,275,824	6	360,000	360,000	3,986,084	67,447	2
3	19	Professional Services	Accumulated Costs	21,275,824	6	20,037	3,986,084	3,754	3	
4	20	Dues, Fees, Subs, & Promos	Accumulated Costs	21,275,824	6	12,115	3,986,084	2,270	4	
5	21	Clerical & General Office Exp.	Accumulated Costs	21,275,824	6	177,210	98,595	3,986,084	33,201	5
6	22	Employee Benefits & PR Taxes	Accumulated Costs	21,275,824	6	57,558	3,986,084	10,784	6	
7	24	Travel & Seminar	Accumulated Costs	21,275,824	6	22,228	3,986,084	4,164	7	
8	25	Other Admin Staff Transport	Accumulated Costs	21,275,824	6	5,078	3,986,084	951	8	
9	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	21,275,824	6	7,113	3,986,084	1,333	9	
10	30	Depreciation	Accumulated Costs	21,275,824	6	22,528	3,986,084	4,221	10	
11	32	Interest Expense	Accumulated Costs	21,275,824	6	49	3,986,084	9	11	
12	34	Rent - Facility & Ground	Accumulated Costs	21,275,824	6	59,034	3,986,084	11,060	12	
13	35	Rent - Equipment & Vehicles	Accumulated Costs	21,275,824	6	10,664	3,986,084	1,998	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					\$ 757,057	\$ 458,595	\$ 141,837	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Capmark Finance, Inc.		X	Refinance Mortgage	\$13,209.94	11/30/06	\$ 2,415,500	\$ 2,341,443	11/30/41	5.6500	\$ 131,697	1							
2												2							
3									Loan Cost Amortization		1,390	3							
4									Interest Income		(6,624)	4							
5									Home Office Allocation		9	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$13,209.94		\$ 2,415,500	\$ 2,341,443			\$ 126,472	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 2,415,500	\$ 2,341,443			\$ 126,472	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,777 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**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			1994		\$ 962,086	\$ 38,483	25	\$ 38,483	\$	\$ 606,114	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Shed	1994		3,247		10			3,247	9
10		Air Conditioner	1994		76,140		10			76,140	10
11		Cabinets	1994		6,809	340	20	340		5,192	11
12		Doors	1994		2,337	117	20	117		1,791	12
13		Electrical	1994		4,601	230	20	230		3,485	13
14		Flooring	1994		25,850		10			25,850	14
15		Exterior Remodeling	1994		4,468	199	15	199		4,468	15
16		Interior Remodeling	1994		66,214	3,696	15	3,696		66,214	16
17		Nurse Call Station	1994		1,960	98	15	98		1,960	17
18		Plumbing	1994		6,619	331	20	331		5,039	18
19		Roof	1994		29,619		10			29,619	19
20		Windows/Gutter	1994		60,254	2,344	15	2,344		60,254	20
21		Siding	1994		15,818	981	15	981		15,818	21
22		Landscaping	1994		3,134		10			3,134	22
23		Parking Lot	1994		29,107		10			29,107	23
24		Flooring	1995		938		10			938	24
25		Metal Doors & Frames	1996		953	48	20	48		643	25
26		Metal Carport	1997		972	65	15	65		794	26
27		Carpet	1997		2,310		5			2,310	27
28		Dining Room Chair Rail	1997		2,230	149	15	149		1,784	28
29		Wallpapering	1997		4,830		5			4,830	29
30		Fire Doors	1997		593	30	20	30		356	30
31		Foliage & Fountains	1997		1,657		10			1,657	31
32		Interior Painting	1997		514		5			514	32
33		Shed	1997		315		10			315	33
34		Door Alarm System	1997		7,840		10			7,840	34
35		Sidewalk Replacement	1997		650	43	15	43		524	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 Nursing & Rehabilitation Center# 0039347

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**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	<u>Beauty Shop Remodeling</u>	1998	\$ 4,287	\$ 214	20	\$ 214		\$ 2,412	37
38	<u>Wallpapering</u>	1998	1,493		5			1,493	38
39	<u>Shower Room Remodeling</u>	1998	1,199	60	20	60		679	39
40	<u>Mini Blinds Installed</u>	1998	509		10			509	40
41	<u>Shelving</u>	1998	566	28	20	28		323	41
42	<u>Baseboard Remodeling</u>	1998	820		10			820	42
43	<u>Water Heater</u>	1998	6,040	403	15	403		4,530	43
44	<u>Folding Doors</u>	1998	456		10			456	44
45	<u>Door Installed</u>	1998	208		10			208	45
46	<u>Wall Mounted Laundry Tub</u>	1998	181	9	20	9		108	46
47	<u>Shower Flooring</u>	1998	401		10			401	47
48	<u>Shed</u>	1998	185		10			185	48
49	<u>Flooring</u>	1998	293		10			293	49
50	<u>Air Conditioning Unit</u>	2000	557	56	10	56		534	50
51	<u>Asphalt Parking Lot</u>	2000	2,360	236	10	236		2,203	51
52	<u>Fire Doors</u>	2001	1,535	102	15	102		878	52
53	<u>Signage</u>	2001	3,318		5			3,318	53
54	<u>Cove Base</u>	2001	1,006	101	10	101		862	54
55	<u>Window Treatments</u>	2001	7,272		5			7,272	55
56	<u>Wallpapering</u>	2001	37,693		5			37,693	56
57	<u>Lobby Carpet</u>	2001	1,433		5			1,433	57
58	<u>Air Conditioning Unit</u>	2001	1,696	170	10	170		1,442	58
59	<u>Cove Base</u>	2002	604	60	10	60		433	59
60	<u>Wallpapering</u>	2002	4,462		5			4,462	60
61	<u>Air Conditioning Unit</u>	2002	1,981	198	10	198		1,519	61
62	<u>Blinds</u>	2002	512		5			512	62
63	<u>Flooring & Cove Base</u>	2002	1,630	163	10	163		1,290	63
64	<u>Wall Guard</u>	2002	1,927	128	15	128		1,006	64
65	<u>Fire Doors</u>	2002	1,042	69	15	69		521	65
66	<u>A/C/Heat Pump Units</u>	2002	1,580	158	10	158		1,172	66
67	<u>Home Office Light Fixtures</u>	2002			10	5	5		67
68	<u>Air Conditioning Unit</u>	2003	3,110	311	10	311		1,984	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,412,421	\$ 49,620		\$ 49,625	\$ 5	\$ 1,040,888	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,412,421	\$ 49,620		\$ 49,625	\$ 5	\$ 1,040,888	1
2	11 Fire Doors	2003	5,950	397	15	397		2,479	2
3	Home Office Cabinets	2003	785		10	78	78	508	3
4	Closet Doors - Resident Rooms	2004	3,628	242	15	242		1,332	4
5	Wiring Outside Lights	2004	1,145	57	10	57		339	5
6	Tile	2004	878	88	10	88		519	6
7	Commercial Water Heater	2004	7,664	766	10	766		4,215	7
8	Floor Tile	2004	1,186	119	10	119		603	8
9	66 Gallon Water Heater	2004	931	93	10	93		473	9
10	Patio & Sidewalks	2004	14,316	954	15	954		5,090	10
11	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		557	11
12	Gravel Parking Lot	2004	3,355	168	5	168		3,355	12
13	Range Hood	2005	832	42	20	42		208	13
14	Closet Doors - Resident Rooms	2005	3,689	369	10	369		1,761	14
15	Outside Light Fixtures	2005	2,025	203	10	203		955	15
16	Air Conditioning Unit	2005	7,609	761	10	761		3,395	16
17	Generator Wiring	2005	1,660	332	5	332		1,494	17
18	Electrical Work	2005	5,528	276	20	276		1,244	18
19	Tile & Cove Base	2005	2,064	206	10	206		912	19
20	Heating/Cooling Unit	2005	558	112	5	112		493	20
21	Wallpaper	2005	810	162	5	162		689	21
22	Therapy Room Cabinets	2005	1,200	80	15	80		320	22
23	New Roof-200 & 500 Wings	2005	74,745	4,983	15	4,983		21,178	23
24	Wall Guard	2006	570	38	15	38		146	24
25	6 Oak Doors	2006	3,469	231	15	231		829	25
26	Smoke Detectors	2006	683	68	10	68		250	26
27	Exhaust Fans for Kitchen	2006	1,034	103	10	103		336	27
28	New Roof-300 Wing	2007	30,200	3,020	10	3,020		8,557	28
29	Shower & Wall Remodel	2007	5,510	275	20	275		804	29
30	Water Heaters	2006	1,696	170	10	170		602	30
31	Air Conditioning Unit	2006	3,414	580	10	580		2,017	31
32	Storage Shed	2006	1,583	158	10	158		561	32
33	Fire Doors	2006	4,939	329	15	329		1,043	33
34	TOTAL (lines 1 thru 33)		\$ 1,607,597	\$ 65,103		\$ 65,186	\$ 83	\$ 1,108,152	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,607,597	\$ 65,103		\$ 65,186	\$ 83	\$ 1,108,152	1
2	Patio and Sidewalks	2006	9,566	638	15	638		2,236	2
3	Wallpaper	2007	779	156	5	156		467	3
4	Upgrade Controls on Call System	2007	1,814	181	10	181		514	4
5	Exhaust Fan Replacement	2007	3,862	386	10	386		837	5
6	Pac-Van 12x36 Office Trailer	2007	18,313	916	20	916		1,908	6
7	New Office Telecommunication Work	2007	2,075	207	10	207		415	7
8	Interior Remodeling-Shower Room	2007	20,896	1,045	20	1,045		2,382	8
9	Water Heaters	2007	10,972	1,097	10	1,097		3,020	9
10	Doors - Metal	2007	4,450	223	20	223		587	10
11	Doors - Wood & Vinyl	2007	2,238	149	15	149		394	11
12	Air Conditioning Units	2007	3,512	702	5	702		1,674	12
13	Flooring	2007	10,399	1,040	10	1,040		2,334	13
14	Light Fixtures	2007	1,794	179	10	179		398	14
15	Home Office New Carpet	2007			10	30	30		15
16	Landscaping - Sign Area	2007	2,575	257	10	257		665	16
17	Repaved Driveway	2007	4,750	594	8	594		1,435	17
18	Flooring	2008	132,076	13,208	10	13,208		20,685	18
19	Wallpapering	2008	45,923	9,185	5	9,185		14,835	19
20	Electrical Work	2008	11,765	588	20	588		925	20
21	5 A/C Units & Installation	2008	8,021	802	10	802		1,271	21
22	Facility Signage	2008	8,602	1,720	5	1,720		2,504	22
23	8 Oak Doors	2008	4,659	311	15	311		414	23
24	In Wall Fountain-Labor & Materials	2008	5,321	760	7	760		1,140	24
25	Corner Guards	2008	2,226	223	10	223		389	25
26	Handrails & Hardware	2008	8,950	597	15	597		1,044	26
27	Chair Rail Materials	2008	807	81	10	81		135	27
28	Cabinets, Countertopr, & Sinks	2008	28,200	1,880	15	1,880		3,290	28
29	Shower Room Plumbing	2008	855	43	20	43		71	29
30	Hot Water Pump	2008	1,425	143	10	143		261	30
31	2 A/C Heat Units	2008	957	191	5	191		271	31
32	Door Guards	2008	1,041	104	10	104		147	32
33	Storage Shed	2008	842	84	10	84		113	33
34	TOTAL (lines 1 thru 33)		\$ 1,967,262	\$ 102,793		\$ 102,906	\$ 113	\$ 1,174,913	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,967,262	\$ 102,793		\$ 102,906	\$ 113	\$ 1,174,913	1
2	5 Shaped Cornices	2008	3,034	303	10	303		404	2
3	Cabinet Installation	2008	3,320	221	15	221		258	3
4	2 New Sidewalks & generator pad	2008	2,050	137	15	137		265	4
5	5 A/C Units	2009	2,951	388	5	388		388	5
6	Sinks/Faucets - Resident Rooms	2009	2,984	34	20	34		34	6
7	Generator	2009	50,432	2,101	20	2,101		2,101	7
8	Roof Replacement - 100 & 400 Halls	2009	36,200	2,413	10	2,413		2,413	8
9	Piping for Sprinklers	2009	1,650	55	25	55		55	9
10	10 Upholstered Cornices	2009	5,255	438	10	438		438	10
11	Wi-Fi Access Installation	2009	1,892	47	20	47		47	11
12	130 Gallon Water Heater	2009	12,706	635	10	635		635	12
13	Ceiling Tiles - Therapy Room	2009	676	23	10	23		23	13
14	Plexiglass for Maint. Shed	2009	758	13	10	13		13	14
15	Closet Doors	2009	548	9	10	9		9	15
16	Gate for Dumpster Enclosure	2009	681	64	8	64		64	16
17	Landscaping - Plants	2009	640	42	10	42		42	17
18	Home Office Shelving	2009	89		15	4	4	4	18
19	Home Office Carpet	2009	702		5	117	117	117	19
20	Home Office Suite 140 Labor & Tenant Finish	2009	3,727		20	140	140	140	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,097,557	\$ 109,716		\$ 110,090	\$ 374	\$ 1,182,363	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 264,901	\$ 22,819	\$ 23,940	\$ 1,121	5-20 yrs	\$ 123,735	71
72	Current Year Purchases	63,475	2,922	3,426	504	5-20 yrs	3,426	72
73	Fully Depreciated Assets	361,098	1,751	1,751		5-10 yrs	361,098	73
74								74
75	TOTALS	\$ 689,474	\$ 27,492	\$ 29,117	\$ 1,625		\$ 488,259	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2004 Ford Wheelchair Van	2004	\$ 35,799	\$	\$	\$	4	\$ 35,799	76
77	See Attached Schedule			10,927		2,222	2,222	4	6,611	77
78										78
79										79
80	TOTALS			\$ 46,726	\$	\$ 2,222	\$ 2,222		\$ 42,410	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,861,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 137,208	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,429	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,221	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,713,032	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

N/A YES NO

16. Rental Amount for movable equipment: \$ 6,593 Description: Postage Machine \$756; Copier \$3,827; Wheelchair \$12, Home Office Vehicle Lease \$1,998

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,014		1,014
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,200		7,200
6	Transportation				
7	Contractual Payments		500		500
8	CNA Competency Tests		1,140		1,140
9	TOTALS	\$	\$ 9,854	\$	\$ 9,854
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,854		

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	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	26

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,8	4973 hrs	\$ 165,068		\$	1,717	4,973	\$ 166,785	1
2	Licensed Speech and Language Development Therapist	10a,8	1950 hrs	88,688				1,950	88,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	5424 hrs	204,015			3,944	5,424	207,959	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				131,344		131,344	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-Rays</u>	39,3				2,551			2,551	12
13	Other (specify): <u>Lab Fees, Spec. Mattre</u>	39,3 39,3				15,401 8,567			15,401 8,567	13
14	TOTAL			\$ 457,771		\$ 26,519	\$ 137,005	12,347	\$ 621,295	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 75,977	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>40,000</u>)	687,520		3
4	Supply Inventory (priced at)	15,660		4
5	Short-Term Investments			5
6	Prepaid Insurance	34,320		6
7	Other Prepaid Expenses	1,016		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 814,493	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	102,378		13
14	Buildings, at Historical Cost	2,017,550		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	711,215		16
17	Accumulated Depreciation (book methods)	(1,701,524)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	174,805		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	44,413		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,369,037	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,183,530	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 631,948	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	171,478		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,587		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Parties</u>	515,525		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,380,538	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,793		39
40	Mortgage Payable	2,385,497		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,578,290	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,958,828	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,775,298)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,183,530	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,863,694)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,863,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	188,396	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	(100,000)	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)	\$ 88,396	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,775,298)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 1/1/2009Ending: 12/31/2009**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	\$ 4,495,524	1
2	Discounts and Allowances for all Levels	(253,659)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,241,865	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	630,927	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 630,927	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,978	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,276	19
20	Radiology and X-Ray	2,741	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,995	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,624	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	52	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,896,463	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	869,757	31
32	Health Care	2,254,425	32
33	General Administration	1,005,631	33
B. Capital Expense			
34	Ownership	357,080	34
C. Ancillary Expense			
35	Special Cost Centers	160,949	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,708,067	40
41	Income before Income Taxes (line 30 minus line 40)**	188,396	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 188,396	43

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

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

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

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center

0039347

Report Period Beginning: 1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,040	2,231	\$ 66,681	\$ 29.89	1
2	Assistant Director of Nursing	1,903	2,170	47,477	21.88	2
3	Registered Nurses	5,057	5,668	113,440	20.01	3
4	Licensed Practical Nurses	23,247	24,778	415,276	16.76	4
5	CNAs & Orderlies	87,277	91,781	853,284	9.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,212	5,458	51,655	9.46	10
11	Social Service Workers	1,724	2,069	35,359	17.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,579	25,203	228,410	9.06	15
16	Dishwashers					16
17	Maintenance Workers	3,011	3,277	48,249	14.72	17
18	Housekeepers	12,926	13,598	119,402	8.78	18
19	Laundry	8,713	9,823	78,274	7.97	19
20	Administrator	1,810	2,080	77,375	37.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,438	3,871	61,821	15.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,815	2,021	19,332	9.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,752	194,028	\$ 2,216,035 *	\$ 11.42	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	106	\$ 5,988	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	12	636	10,3	37
38	Nurse Consultant	8	638	10,3	38
39	Pharmacist Consultant	Contract	1,160	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	520	11,3	44
45	Social Service Consultant	8	520	12,3	45
46	Other(specify)				46
47	Quality Assurance Nurse	N/A	27,825	10,3	47
48	Clerical	N/A	16,690	21,3	48
49	TOTAL (lines 35 - 48)	142	\$ 63,577		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center# 0039347Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association \$3797
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,062 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 38.55%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: May, Cocagne, & King
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

MONTGOMERY NURSING & REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2009

Miscellaneous Income	6
Medicaid Payment	40
Bank Fee from Archer	6
	<hr/>
	52
	<hr/>

Montgomery Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2009

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	\$ 188,396
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>87,157</u>
SUBTOTAL	275,553
DEPRECIATION ADJUSTMENT	(206,503)
MISC. NON-DEDUCTIBLE EXPENSE	58,135
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>\$ 127,185</u></u>

MONTGOMERY NURSING & REHAB CENTER, INC.
 TRAVEL AND SEMINAR SCHEDULE
 ATTACHMENT TO SCHEDULE XIX PART G
 12/31/2009

<u>Seminar Participant</u>	<u>Job Title</u>	<u>Dates</u>	<u>City</u>	<u>Title of Seminar</u>	<u>Sponsor</u>	<u>Cost</u>	<u>Seminar Lodging Travel/Meals</u>
Mark Weible	Director of Operations	2/27/2009	Lagrange	Administrative License Course	Contentental Testing	40	
Mark Weible	Director of Operations	2/28/2009	Springfield	Administrative License Course	Pes Nabe Testing Office	53	
Larry Wood	Maintenance	6/1/2009	Jerseyville	Epoxy Flooring Installation	American Hi-Tech Flooring	522	
Ginny Turner, Pam Jones	Medical Records, Activities Asst.	7/1/2009	Online	Defensive Driving Course	NHRMA Mutual	65	
Mark Weible	Director of Operations	11/20/2009	Springfield	Administrative License Course	Pes Nabe Testing Office	53	
Cindi Paden, Pam Jones	Activity Director, Activity Assistant	11/14 - 11/16/09	Springfield	2009 IAPA Conference	Illinois Activity Professionals Association	550	281
Shannon Moore	Care Plan Coordinator	11/11/2009	Springfield	Be a MDS Hero	Illinois Healthcare Association	100	54
Carla Vonder Haar, Ramona Tomazzoli, Deb Schulte	Administrator, DON, ADON	4/14/2009	Springfield	What's new in the World of Infectious Disease	IL. Dept. of Professional Regulation	300	26
Ramona Tomazzoli, Tammy Richmond	DON, Social Service Director	7/14/2009	Springfield	New Quality of Life Revisions to LTC Surveyors	Illinois Healthcare Association	240	86
Shannon Moore, Ramona Tomazzoli	Care Plan Coordinator, DON	8/11/2009	Springfield	HFS MDS Medicaid Audit Results	Illinois Healthcare Association	190	60
Cathy Brummet	Dietary Supervisor	10/31/2009	Springfield	CDM, CFPP Credentialing Exam	Dietary Managers Association	380	
						2493	507
Total Seminar Lodging/Travel/Meals						507	
CPR Training						500	
Other Travel Expenses <\$250						5144	
Home Office Travel & Seminar						4164	
Total Travel & Seminar, Line 24						12808	