

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	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	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	40	TOTALS	40	14,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,374		11,431	12,805	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,374		11,431	12,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.71%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/28/1992

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 14 and days of care provided 3,800

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2009 Fiscal Year: 6/30/2009

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	703,241	92,774	5,177	801,192		801,192	(506,968)	294,224		1
2	Food Purchase		496,929		496,929		496,929	(326,086)	170,843		2
3	Housekeeping	248,757	48,697	16,472	313,926		313,926	(305,023)	8,903		3
4	Laundry	43,100	14,637	1,899	59,636		59,636		59,636		4
5	Heat and Other Utilities			506,501	506,501		506,501	(492,054)	14,447		5
6	Maintenance	239,588	4,492	349,270	593,350		593,350	(391,327)	202,023		6
7	Other (specify):*										7
8	TOTAL General Services	1,234,686	657,529	879,319	2,771,534		2,771,534	(2,021,458)	750,076		8
	B. Health Care and Programs										
9	Medical Director			34,389	34,389		34,389		34,389		9
10	Nursing and Medical Records	1,059,656	49,533	36,265	1,145,454		1,145,454	(101)	1,145,353		10
10a	Therapy		1,360	396,707	398,067		398,067		398,067		10a
11	Activities	75,794	646	12,315	88,755		88,755		88,755		11
12	Social Services	13,294			13,294		13,294		13,294		12
13	CNA Training										13
14	Program Transportation	45,506	90	9,722	55,318		55,318	(41,616)	13,702		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,194,250	51,629	489,398	1,735,277		1,735,277	(41,717)	1,693,560		16
	C. General Administration										
17	Administrative					94,953	94,953	(62,623)	32,330		17
18	Directors Fees										18
19	Professional Services			216,098	216,098	(14,049)	202,049	(143,835)	58,214		19
20	Dues, Fees, Subscriptions & Promotions			33,067	33,067	14,049	47,116	(31,074)	16,042		20
21	Clerical & General Office Expenses	635,038	22,151	208,891	866,080	(94,953)	771,127	(550,974)	220,153		21
22	Employee Benefits & Payroll Taxes			1,144,578	1,144,578		1,144,578	(628,773)	515,805		22
23	Inservice Training & Education			11,314	11,314		11,314	(7,462)	3,852		23
24	Travel and Seminar			14,834	14,834		14,834	(11,132)	3,702		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			203,715	203,715		203,715	(197,905)	5,810		26
27	Other (specify):*			48,133	48,133		48,133	(48,133)			27
28	TOTAL General Administration	635,038	22,151	1,880,630	2,537,819		2,537,819	(1,681,911)	855,908		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,063,974	731,309	3,249,347	7,044,630		7,044,630	(3,745,086)	3,299,544		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.

Facility Name & ID Number Montgomery Place

#0037515

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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			1,903,331	1,903,331		1,903,331	(1,584,212)	319,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,931,859	1,931,859		1,931,859	(1,876,761)	55,098			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			45,200	45,200		45,200	(29,810)	15,390			35
36	Other (specify):*											36
37	TOTAL Ownership			3,880,390	3,880,390		3,880,390	(3,490,783)	389,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,614	24,423	170,037		170,037		170,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,410	55,410		55,410		55,410			42
43	Other (specify):*	361,980	48,768	689,585	1,100,333		1,100,333	(1,100,333)				43
44	TOTAL Special Cost Centers	361,980	194,382	769,418	1,325,780		1,325,780	(1,100,333)	225,447			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,425,954	925,691	7,899,155	12,250,800		12,250,800	(8,336,202)	3,914,598			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

Part V - Reclassifications

		From Line	To Line
HUB service fee	14,049	19	20
Administrator wages	94,953	21	17

STATE OF ILLINOIS

Facility Name & ID Number

Montgomery Place

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Report Period Beginning:

7/1/2008 Ending:

Part V Supplement

6/30/2009

Schedule V; Line 23.3 Inservice Training & Education

Date	Payee	Topic	Attendee	Job Class	Location	Fee
7/231/09	DEMITRIS FRANKLIN	7/08 PETTY CASH				20.00
8/6/2009	ELAINE AYOT	Customer Service Training	ELAINE AYOT	Management	Ritz Carlton	16.00
8/6/2009	Gladys Corrales	Customer Service Training	Gladys Corrales	Management	Ritz Carlton	43.00
8/29/2008	AAHSA	AAHSA Meeting	Robert Heller	CFO	Philadelphia	722.36
8/29/2008		Reclassified				250.00
8/29/2008		Reclassified				595.82
8/29/2008	AAHSA	AAHSA Meeting	Michael Apa	ED	Philadelphia	722.36
9/11/2008	AAHSA	AASHA Meeting	Mary VonGoeben	Administrator	Philadelphia	715.00
9/11/2008	United Airlines/ AAHSA	AASHA Meeting	Mary VonGoeben	Administrator	Philadelphia	297.28
9/11/2008	United Airlines/ AAHSA	AASHA Meeting	Robert Heller	CFO	Philadelphia	271.35
9/12/2008	United Airlines/ AAHSA	AASHA Meeting	Michael Apa	ED	Philadelphia	329.94
10/23/2009	Michael Apa	Auto Millage - AAHSA	Michael Apa	ED	Philadelphia	60.60
10/23/2009	Michael Apa	Transport - AAHSA	Michael Apa	ED	Philadelphia	133.00
10/23/2009	Michael Apa	Lunched - AAHSA	Michael Apa	ED	Philadelphia	54.77
10/23/2009	Michael Apa	Tips - AAHSA	Michael Apa	ED	Philadelphia	50.00
10/23/2009	Michael Apa	Parking - AAHSA	Michael Apa	ED	Philadelphia	8.00
10/24/2008	Robert Heller	Parking - AAHSA	Robert Heller	CFO	Philadelphia	94.20
10/24/2008	Robert Heller	Transport - AAHSA	Robert Heller	CFO	Philadelphia	54.00
10/24/2008	Robert Heller	Local Transport - AAHSA	Robert Heller	CFO	Philadelphia	172.00
10/24/2009	Michael Apa	Meals - AAHSA	Michael Apa	ED	Philadelphia	129.00
11/3/2008	Michael Apa	Meal - Ziegler Conference	Michael Apa	ED	San Francisco	6.95
11/4/2008	Michael Apa	Food - Ziegler Conference	Michael Apa	ED	San Francisco	24.25
11/4/2008	Michael Apa	Taxi - Ziegler Conference	Michael Apa	ED	San Francisco	62.00
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	9.97
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	4.23
11/4/2008	Michael Apa	Local Transport - Ziegler Conference	Michael Apa	ED	San Francisco	57.00
11/4/2008	Michael Apa	Lodging - Ziegler Conference	Michael Apa	ED	San Francisco	961.17
11/4/2008	Michael Apa	Lodging - Ziegler Conference	Michael Apa	ED	San Francisco	202.41
11/4/2008	Michael Apa	Taxi - Ziegler Conference	Michael Apa	ED	San Francisco	23.05
11/4/2008	Michael Apa	Airline Ticket - Ziegler Conference	Michael Apa	ED	San Francisco	40.00
11/4/2008	Michael Apa	Lodging - Ziegler Conference	Michael Apa	ED	San Francisco	961.17

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Report Period Beginning:

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Part V Supplement

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Schedule V; Line 23.3 Inservice Training & Education

Date	Payee	Topic	Attendee	Job Class	Location	Fee
11/4/2008	Michael Apa	Taxi - Ziegler Conference	Michael Apa	ED	San Francisco	63.00
11/4/2008	Michael Apa	Lodging - Ziegler Conference	Michael Apa	ED	San Francisco	30.00
11/4/2008	Michael Apa	Airline Ticket - Ziegler Conference	Michael Apa	ED	San Francisco	40.00
11/4/2008	Michael Apa	Lodging - Ziegler Conference	Michael Apa	ED	San Francisco	62.88
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	5.46
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	106.45
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	15.00
11/4/2008	Michael Apa	Food/ Dinning - Ziegler Conference	Michael Apa	ED	San Francisco	107.45
11/4/0/8		HOME DEPOT				125.00
11/4/2008		CANDIES				56.69
11/7/2008	Mary VonGoeben	Taxi - AAHSA	Mary VonGoeben	Administrator	Philadelphia	95.00
11/7/2008	Mary VonGoeben	Dinner - AAHSA	Mary VonGoeben	Administrator	Philadelphia	46.73
11/7/2008	Mary VonGoeben	Breakfast - AAHSA	Mary VonGoeben	Administrator	Philadelphia	27.25
11/7/2008	Mary VonGoeben	Lunch - AAHSA	Mary VonGoeben	Administrator	Philadelphia	21.62
12/8/2009	Crowne Plaza Hotel	Lodging - AAHSA Conference	Michael Apa	ED	Philadelphia	1,294.49
12/8/2009	Crowne Plaza Hotel	Lodging - AAHSA Conference	Mary VonGoeben	Administrator	Philadelphia	1,325.53
12/8/2008	Crowne Plaza Hotel	Lodging - AAHSA Conference	Robert Heller	CFO	Philadelphia	1,330.05
12/8/2008	Morton of Atlantic	Dinner - AAHSA	Senior Management	Senior Management	New Jersey	398.25
12/8/2008	Davio's	Dinner - AAHSA	Senior Management	Senior Management	Philadelphia	377.34
12/8/2008	McCormick	Dinner - AAHSA	Senior Management	Senior Management	Philadelphia	218.60
2/11/2009	Wildfire	Employee Lunch	Wildfire	Management	Chicago	1,387.66
3/13/2009	Emily Vogel	Parking - LSN	Emily Vogel	Marketing Specialist	Chicago	112.58
3/13/2009	Emily Vogel	Mileage LSN	Emily Vogel	Marketing Specialist	Chicago	6.92
3/13/2009	Emily Vogel	Food - LSN	Emily Vogel	Marketing Specialist	Chicago	21.66
3/13/2009	Emily Vogel	Taxi - LSN	Emily Vogel	Marketing Specialist	Chicago	1.95
3/13/2009	Emily Vogel	Food - LSN	Emily Vogel	Marketing Specialist	Chicago	22.05
3/13/2009	Emily Vogel	Taxi - LSN	Emily Vogel	Marketing Specialist	Chicago	20.00
3/13/2009	Robert Heller	Parking - LSN	Robert Heller	CFO	Chicago	40.00
2/11/2009	Michael Apa	Mileage Reimbursement	Michael Apa	ED	Chicago	461.83
2/11/2009	Virgin Airlines	Air tickets - IAHSA	Virgin Airlines	ED/ Spouse	London	1,451.93
3/13/2009	Laura Zellhofer	Parking - LSN	Laura Zellhofer	Marketing Specialist	Chicago	52.50

Facility Name & ID Number

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STATE OF ILLINOIS

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Report Period Beginning:

7/1/2008 Ending:

Part V Supplement

6/30/2009

Schedule V; Line 23.3 Inservice Training & Education

Date	Payee	Topic	Attendee	Job Class	Location	Fee
3/13/2009	Emily Vogel	Parking - LSN	Emily Vogel	Marketing Specialist	Chicago	39.55
12/1/2008	Emily Vogel	Mileage - Visit with Client	Emily Vogel	Marketing Specialist	Chicago	139.56
11/17/2009	Gilda Mathis	Mileage - Dementia Classes	Gilda Mathis	Activities Director	Chicago	157.02
			Genreal Ledger Reclassification Adjustments			<u>(5,438.88)</u>
					Subtotal	11,314
		Remove AL/IL allocated costs				<u>(7,462)</u>
				Schedule V; Line 23.	Total	<u>3,852</u>

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	(31,711)	2		4
5	Telephone, TV & Radio in Resident Rooms	(84,370)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(135)	32		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	(54,337)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(8,165,649)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,336,202)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (8,336,202)		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 PlaceID# 0037515Report Period Beginning: 07/01/2008Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL Dietary	\$ (506,968)	1	1
2	AL/IL Food Purchases	(294,375)	2	2
3	AL/IL Housekeeping	(303,243)	3	3
4	Revenue Offset - Housekeeping	(1,780)	3	4
5	AL/IL Heat & Other Utilities	(492,054)	5	5
6	AL/IL Maintenance	(391,327)	6	6
7	Revenue Offset - Medical Records	(101)	10	7
8	AL/IL Transportation	(26,540)	14	8
9	Revenue Offset - Transportation	(15,076)	14	9
10	AL/IL Administrator	(62,623)	17	10
11	AL/IL Professional Services	(112,763)	19	11
12	Unallowable Legal Expenses	(31,072)	19	12
13	AL/IL Dues, Fees, & Subscriptions	(31,074)	20	13
14	AL/IL Office & Clerical	(426,443)	21	14
15	Bank Charges	(15)	21	15
16	Revenue Offset - Admin Fees	(36,000)	21	16
17	Music Fund Expenses	(445)	21	17
18	Library Fund Expenses	(3,701)	21	18
19	AL/IL Employee Benefits	(496,053)	22	19
20	Marketing - Specific Employee Benefits	(84,269)	22	20
21	AL/IL - Specific Employee Benefits	(48,451)	22	21
22	AL/IL Travel & Seminar	(7,172)	24	22
23	Unsupported Travel & Seminar	(3,960)	24	23
24	AL/IL Insurance	(197,905)	26	24
25	Late Fees/Service Charges	(439)	27	25
26	Prior year items (remove credit)	6,643	27	26
27	AL/IL Equipment Depreciation Expense	(1,584,212)	30	27
28	AL/IL Interest Expense	(1,876,626)	32	28
29	AL/IL Equipment Rental	(29,810)	35	29
30	ILU - Specific Expenses	(152,304)	43	30
31	Marketing - Specific Expenses	(948,029)	43	31
32	AL/IL Inservice	(7,462)	23	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	(8,165,649)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(506,968)	0	0	0	0	0	0	0	0	0	0	(506,968)	1
2	Food Purchase	(326,086)	0	0	0	0	0	0	0	0	0	0	(326,086)	2
3	Housekeeping	(305,023)	0	0	0	0	0	0	0	0	0	0	(305,023)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(492,054)	0	0	0	0	0	0	0	0	0	0	(492,054)	5
6	Maintenance	(391,327)	0	0	0	0	0	0	0	0	0	0	(391,327)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,021,458)	0	(2,021,458)	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	(101)	0	0	0	0	0	0	0	0	0	0	(101)	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	(41,616)	0	0	0	0	0	0	0	0	0	0	(41,616)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(41,717)	0	(41,717)	16									
	C. General Administration													
17	Administrative	(62,623)	0	0	0	0	0	0	0	0	0	0	(62,623)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(143,835)	0	0	0	0	0	0	0	0	0	0	(143,835)	19
20	Fees, Subscriptions & Promotions	(31,074)	0	0	0	0	0	0	0	0	0	0	(31,074)	20
21	Clerical & General Office Expenses	(550,974)	0	0	0	0	0	0	0	0	0	0	(550,974)	21
22	Employee Benefits & Payroll Taxes	(628,773)	0	0	0	0	0	0	0	0	0	0	(628,773)	22
23	Inservice Training & Education	(7,462)	0	0	0	0	0	0	0	0	0	0	(7,462)	23
24	Travel and Seminar	(11,132)	0	0	0	0	0	0	0	0	0	0	(11,132)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(197,905)	0	0	0	0	0	0	0	0	0	0	(197,905)	26
27	Other (specify):*	(48,133)	0	0	0	0	0	0	0	0	0	0	(48,133)	27
28	TOTAL General Administration	(1,681,911)	0	(1,681,911)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,745,086)	0	(3,745,086)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

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	(1,584,212)	0	0	0	0	0	0	0	0	0	0	(1,584,212)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,876,761)	0	0	0	0	0	0	0	0	0	0	(1,876,761)	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	(29,810)	0	0	0	0	0	0	0	0	0	0	(29,810)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,490,783)	0	0	0	0	0	0	0	0	0	0	(3,490,783)	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):*	(1,100,333)	0	0	0	0	0	0	0	0	0	0	(1,100,333)	43
44	TOTAL Special Cost Centers	(1,100,333)	0	0	0	0	0	0	0	0	0	0	(1,100,333)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,336,202)	0	0	0	0	0	0	0	0	0	0	(8,336,202)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		Hyde Park Home	Hyde Park	Home Health
				Care		Agency

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

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

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

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2008Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Montgomery Place Independent Living

Street Address

5550 South Shore Drive

City / State / Zip Code

Chicago, IL 60637

Phone Number

(574) 753-4100

Fax Number

(574) 752-0056

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Meals	104,958	2	\$ 801,192	\$ 258,253	38,544	\$ 294,224	1
2	2	Food	Meals	104,958	2	465,218		38,544	170,843	2
3	3	Housekeeping	Square Feet	203,488	2	312,146	7,095	5,804	8,903	3
4	5	Utilities	Square Feet	203,488	2	506,501		5,804	14,447	4
5	6	Maintenance	Revenue	9,836,849	2	593,350	81,575	3,349,244	202,023	5
6	14	Program Transportation	Revenue	9,836,849	2	40,242	15,494	3,349,244	13,702	6
7	17	Administrative	Revenue	9,836,849	2	94,953	32,330	3,349,244	32,330	7
8	19	Professional Fees	Revenue	9,836,849	2	170,977		3,349,244	58,214	8
9	20	Dues and Subscriptions	Revenue	9,836,849	2	47,116		3,349,244	16,042	9
10	21	Clerical & General Office	Revenue	9,836,849	2	646,596	216,217	3,349,244	220,153	10
11	22	Employee Benefits	Salary	3,425,954	2	1,011,858		1,746,414	515,805	11
12	23	Inservice Training	Revenue	9,836,849	2	11,314		3,349,244	3,852	12
13	24	Travel & Seminar	Revenue	9,836,849	2	10,874		3,349,244	3,702	13
14	26	Insurance	Square Feet	203,488	2	203,715		5,804	5,810	14
15	30	Depreciation	Actual	1,903,331	2	1,903,331		319,119	319,119	15
16	32	Interest	Square Feet	203,488	2	1,931,724		5,804	55,098	16
17	35	Equipment Rental	Revenue	9,836,849	2	45,200		3,349,244	15,390	17
18	4	Laundry	Actual	59,636	1	59,636		59,636	59,636	18
19	9	Medical Director	Actual	34,389	1	34,389		34,389	34,389	19
20	10	Nursing/Medical Records	Actual	1,145,353	1	1,145,353	1,059,656	1,145,353	1,145,353	20
21	10a	Therapy	Actual	398,067	1	398,067		398,067	398,067	21
22	11	Activities	Actual	88,755	1	88,755	75,794	88,755	88,755	22
23	39	Ancillary	Actual	170,037	1	170,037		170,037	170,037	23
24	42	Provider Participation Fee	Actual	55,410	1	55,410		55,410	55,410	24
25	TOTALS					\$ 10,747,954	\$ 1,746,414		\$ 3,901,304	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	Illinois Finance Authority		x	Revenue Bonds	N/A	11/20/06	\$ 40,850,000	\$ 35,395,000	05/2038	Variable	\$ 1,931,724	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 40,850,000	\$ 35,395,000			\$ 1,931,724	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 40,850,000	\$ 35,395,000			\$ 1,931,724	15							

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

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

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.)

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,804 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Montgomery Place Retirement Community, 170,401 Square Feet, 160 Units

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	40	1992	1992	\$ 5,735,741	\$	40	\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9			1997	20,111					
10	Various		1998	19,268					
11	Various		1999	40,652					
12	Various		2000	143,621					
13	Various		2001	117,397					
14	Various		2002	68,258					
15	Various		2003	95,898					
16	Various		2004	76,985					
17	Various		2005	7,058					
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2008 Ending: 06/30/2009**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	Elevator keypads	2006	\$ 3,068	\$	20	\$	\$	\$	37
38	Elevator work	2006	6,221		20				38
39	Elevator shaft smoke detectors	2006	3,433		20				39
40	Elevator cab design fees	2006	482		20				40
41	New piping in kitchen	2006	1,575		20				41
42	Door systems	2007	395		20				42
43	Door systems	2007	294		20				43
44	Fan coil motors	2007	178		20				44
45	Water ball valves	2007	7,023		20				45
46	Gas valve	2007	433		20				46
47	Motor, coupling, freeze stat	2007	627		20				47
48	Air flow fan	2007	220		20				48
49	Door gasket for cooler	2007	295		20				49
50	Riser leak repair	2007	233		20				50
51	Repair chiller	2007	1,502		20				51
52	Elevator	2007	877		20				52
53	Elevator	2008	3,481		20				53
54	Building canopy & façade	2009	5,788		20				54
55									55
56									56
57									57
58									58
59									59
60									60
61	Total nursing facility depreciation expense			319,119		319,119		2,245,137	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,361,114	\$ 319,119		\$ 319,119	\$	\$ 2,245,137	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 Place

0037515

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	\$ 1,115,937	\$	\$	\$	10	\$	71
72	Current Year Purchases	15,859				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,131,796	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1999 Plymouth Voyager	2004	\$ 1,382	\$	\$	\$	5	\$	76
77	Facility	2005 Glaval Universal Bus	2004	12,922				5		77
78	Facility	Auto	2007	4,110				5		78
79										79
80	TOTALS			\$ 18,414	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,402,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 319,119	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 319,119	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,245,137	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living Alloc	\$ 41,713,977	\$ 1,584,212	\$ 15,085,340	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 41,713,977	\$ 1,584,212	\$ 15,085,340	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 45,234	92
93			93
94			94
95		\$ 45,234	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 45,200 Description: Office/Admin Equipment \$43,735 and Miscellaneous As-Needed \$1,465

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a Col. 2 & 3	hrs	\$	2,537	\$ 179,152	\$ 935	2,537	\$ 180,087	1						
2	Licensed Speech and Language Development Therapist	10a Col. 2 & 3	hrs		60	5,672		60	5,672	2						
3	Licensed Recreational Therapist		hrs							3						
4	Licensed Physical Therapist	10a Col. 2 & 3	hrs		3,354	211,883	425	3,354	212,308	4						
5	Physician Care		visits							5						
6	Dental Care		visits							6						
7	Work Related Program		hrs							7						
8	Habilitation		hrs							8						
9	Pharmacy		# of prescripts							9						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10						
11	Academic Education		hrs							11						
12	Other (specify): _____									12						
13	Other (specify): _____									13						
14	TOTAL			\$	5,951	\$ 396,707	\$ 1,360	5,951	\$ 398,067	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 534,669	\$	1
2	Cash-Patient Deposits	699,146		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (63,289))	230,922		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,447,487		5
6	Prepaid Insurance	119,031		6
7	Other Prepaid Expenses	42,261		7
8	Accounts Receivable (owners or related parties)	235,454		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,308,970	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,944,409		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	41,980,418		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,882,696		16
17	Accumulated Depreciation (book methods)	(17,330,477)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	8,849,879		21
22	Other Long-Term Assets (spe CIP)	45,234		22
23	Other(specify): <u>See Supplemental Schedule</u>	1,764,933		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,390,704	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 49,699,674	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 367,332	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	632,168		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	246,739		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	106,558		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	2,874,141		36
37	<u>FV Adjustment</u>	77,053		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,303,991	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	35,395,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Original Bond Issue Premium, net</u>	661,964		43
44	<u>See Supplemental Schedule</u>	14,622,872		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 50,679,836	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 54,983,827	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,284,153)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 49,699,674	\$	48

XV. BALANCE SHEET - Supplemental Schedule

Line 28 - Other Assets

<u>Description</u>	<u>Amount</u>
Capitalized interest	\$ 413,288
Bond financing costs, net	1,350,885
Capitalized marketing costs, net	760
	<u>\$ 1,764,933</u>

Line 36 - Other Short-term Liabilities

<u>Description</u>	<u>Amount</u>
Accrued Medical Director Fee	\$ 11,537
Accrued HC Bed Taxes	4,278
Due to affiliate (Church Home)	2,858,326
	<u>\$ 2,874,141</u>

Line 44 - Other Long-term Liabilities

<u>Description</u>	<u>Amount</u>
Resident deposits, refundable	\$13,992,686
Independent living security deposits	437,032
HC Resident trust funds	3,687
HC Security Deposits	189,467
	<u>\$14,622,872</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,564,022)	1
2	Restatements (describe):		2
3	Adjust equity to 6/30/08 financial statement	258,956	3
4	(Financial Statement was not available for 6/30/08 cost report filing.)		4
5	Adjustment by Montgomery Place after audit	(28,568)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,333,634)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(950,519)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (950,519)	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)	\$ (5,284,153)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 07/01/2008Ending: 06/30/2009

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	\$ 3,349,244	1
2	Discounts and Allowances for all Levels	(730,012)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,619,232	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	714,948	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 714,948	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,610	13
14	Non-Patient Meals	31,711	14
15	Telephone, Television and Radio	84,370	15
16	Rental of Facility Space	149,592	16
17	Sale of Drugs	126,753	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,335	19
20	Radiology and X-Ray	7,400	20
21	Other Medical Services	172,886	21
22	Laundry	10,130	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 610,787	23
D. Non-Operating Revenue			
24	Contributions	355,020	24
25	Interest and Other Investment Income***	346,724	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 701,744	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	6,653,570	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,653,570	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,300,281	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,771,534	31
32	Health Care	1,735,277	32
33	General Administration	2,537,819	33
B. Capital Expense			
34	Ownership	3,880,390	34
C. Ancillary Expense			
35	Special Cost Centers	1,270,370	35
36	Provider Participation Fee	55,410	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,250,800	40
41	Income before Income Taxes (line 30 minus line 40)**	(950,519)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (950,519)	43

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

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

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

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

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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

<u>Description</u>	<u>Amount</u>
Independent Living	\$ 6,487,605
Miscellaneous Income	76,564
Medical Records	101
Vending	1,002
Various Funds (Employee, Music, Library, etc.)	4,433
Administration Fee Revenue	36,000
Cell Tower Revenue	27,664
Massage Revenue	3,345
Housekeeping Services	1,780
Transportation	15,076
	<u>\$ 6,653,570</u>

Line 25 Interest and Other Investment Income

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

Facility Name & ID Number **Montgomery Place**

0037515

Report Period Beginning: **07/01/2008**

Ending:

06/30/2009

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	1,712	1,911	\$ 106,263	\$ 55.61	1
2	Assistant Director of Nursing	1,881	2,156	70,957	32.91	2
3	Registered Nurses	3,300	3,592	123,801	34.47	3
4	Licensed Practical Nurses	18,518	20,680	473,448	22.89	4
5	CNAs & Orderlies	31,040	34,087	351,096	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,368	1,439	28,559	19.85	9
10	Activity Assistants	4,461	4,812	42,815	8.90	10
11	Social Service Workers	692	703	13,512	19.22	11
12	Dietician	1,864	2,057	37,495	18.23	12
13	Food Service Supervisor	4,047	4,113	79,908	19.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,862	28,757	314,878	10.95	15
16	Dishwashers	9,405	10,321	96,901	9.39	16
17	Maintenance Workers	8,089	8,222	127,575	15.52	17
18	Housekeepers	22,403	25,253	286,776	11.36	18
19	Laundry	3,853	4,270	52,286	12.24	19
20	Administrator	1,632	1,916	94,953	49.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,493	2,751	64,657	23.50	23
24	Clerical	35,417	35,998	455,862	12.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,003	2,257	38,714	17.15	31
32	Other Health C: Admissions	995	1,011	29,904	29.58	32
33	Other(specify) <u>See Supplemental</u>	25,401	27,020	535,594	19.82	33
34	TOTAL (lines 1 - 33)	206,436	223,326	\$ 3,425,954 *	\$ 15.34	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		\$ 5,177	1.3	35
36	Medical Director		34,389	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,317	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		2,153	11.3	44
45	Social Service Consultant				45
46	Other(specify) <u>Lab Services</u>		7,376	39.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 50,412		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	0	\$ 0		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2**	3	4
	Description	# of Hrs.	# of Hrs.	Reporting Period	Average
		Actually	Paid and	Total Salaries,	Hourly
		Worked	Accrued	Wages	Wage
33 A	Security	\$ 6,536	6,643	\$ 103,763	\$ 15.62
33 B	Transportation	4,137	4,494	48,258	11.66
33 C	Marketing	8,687	9,603	254,940	26.55
33 D	Salaries & Wages - AL	3,521	3,579	72,940	20.38
33 E	Activity Director - IL	<u>2,520</u>	<u>2,701</u>	<u>55,693</u>	<u>20.62</u>
	Total Line 33	<u>\$ 25,401</u>	<u>27,020</u>	<u>\$ 535,594</u>	<u>\$ 19.82</u>

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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 Place# 0037515Report Period Beginning: 07/01/2008Ending: 06/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,209 Line 10.2
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,410
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (Ind. Living) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,914
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe Horwath LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT