

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 N/A

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,095	7,217	4,566	12,878	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,095	7,217	4,566	12,878	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.21%

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 01/28/1992

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 4,266

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	810,879	117,073	12,460	940,412	113	940,525	(596,282)	344,243		1
2	Food Purchase		682,220		682,220		682,220	(452,977)	229,243		2
3	Housekeeping	243,523	52,285	2,577	298,385	76	298,461	(291,216)	7,245		3
4	Laundry	53,006	18,619	2,116	73,741		73,741	(13,982)	59,759		4
5	Heat and Other Utilities			473,514	473,514		473,514	(461,039)	12,475		5
6	Maintenance	293,457	22,207	310,646	626,310	19	626,329	(395,253)	231,076		6
7	Other (specify):*										7
8	TOTAL General Services	1,400,865	892,404	801,313	3,094,582	208	3,094,790	(2,210,749)	884,041		8
	B. Health Care and Programs										
9	Medical Director			26,091	26,091		26,091		26,091		9
10	Nursing and Medical Records	1,337,158	57,244	22,499	1,416,901		1,416,901	(224)	1,416,677		10
10a	Therapy		1,905	645,005	646,910		646,910		646,910		10a
11	Activities	88,193	1,170	13,164	102,527		102,527		102,527		11
12	Social Services	75,428	153	508	76,089		76,089		76,089		12
13	CNA Training										13
14	Program Transportation	44,525	419	3,406	48,350		48,350	(35,724)	12,626		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,545,304	60,891	710,673	2,316,868		2,316,868	(35,948)	2,280,920		16
	C. General Administration										
17	Administrative					121,658	121,658	(76,503)	45,155		17
18	Directors Fees										18
19	Professional Services			139,303	139,303	(3,656)	135,647	(93,308)	42,339		19
20	Dues, Fees, Subscriptions & Promotions			26,042	26,042		26,042	(17,633)	8,409		20
21	Clerical & General Office Expenses	894,859	11,049	121,818	1,027,726	(121,658)	906,068	(621,399)	284,669		21
22	Employee Benefits & Payroll Taxes			911,816	911,816	3,697	915,513	(479,380)	436,133		22
23	Inservice Training & Education										23
24	Travel and Seminar			25,337	25,337	(4,024)	21,313	(14,189)	7,124		24
25	Other Admin. Staff Transportation					119	119	(75)	44		25
26	Insurance-Prop.Liab.Malpractice			174,611	174,611		174,611	(169,631)	4,980		26
27	Other (specify):* Unallowable Exp			69,373	69,373		69,373	(69,373)			27
28	TOTAL General Administration	894,859	11,049	1,468,300	2,374,208	(3,864)	2,370,344	(1,541,491)	828,853		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,841,028	964,344	2,980,286	7,785,658	(3,656)	7,782,002	(3,788,188)	3,993,814		29

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

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

Facility Name & ID Number

Montgomery Place

#0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			2,686,558	2,686,558		2,686,558	(2,269,688)	416,870			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,918,315	1,918,315		1,918,315	(1,863,898)	54,417			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,779	20,779		20,779	(13,067)	7,712			35
36	Other (specify):*			44,635	44,635	3,656	48,291	(46,934)	1,357			36
37	TOTAL Ownership			4,670,287	4,670,287	3,656	4,673,943	(4,193,587)	480,356			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		158,907	13,073	171,980		171,980		171,980			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,631	98,631		98,631		98,631			42
43	Other (specify):* AL/IL & Mktg	472,004	74,413	633,212	1,179,629		1,179,629	(1,179,629)				43
44	TOTAL Special Cost Centers	472,004	233,320	744,916	1,450,240		1,450,240	(1,179,629)	270,611			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,313,032	1,197,664	8,395,489	13,906,185		13,906,185	(9,161,404)	4,744,781			45

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

SCHEDULE V, COLUMN 5 - RECLASSIFICATIONS

		To Line	From Line
Administrator wages	\$ 121,658	17	21
Engineer assistance with kitchen renovations	3,656	36	19
Dietary supplies	113	1	24
Housekeeping supplies	76	3	24
Maintenance supplies	19	6	24
Employee benefits	3,697	22	24
Other Admin Travel	119	25	24

SCHEDULE V, PART D OWNERSHIP, LINE 36 DETAIL

Engineer assistance with kitchen renovations \$ 3,656

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	(54,938)	2		4
5	Telephone, TV & Radio in Resident Rooms	(36,125)	5		5
6	Rented Facility Space	(26,719)	3		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	(10,453)	32		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	(1,853,445)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(36,001)	21		17
18	Fines and Penalties	(4,936)	27		18
19	Entertainment				19
20	Contributions	(25)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,412)	27		24
25	Fund Raising, Advertising and Promotional	(892,876)	43		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	(6,181,474)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,161,404)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (9,161,404)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Montgomery PlaceID# 0037515Report Period Beginning: 7/1/2012Ending: 6/30/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL Dietary Costs	\$ (596,282)	1	1
2	AL/IL Food Purchases	(397,085)	2	2
3	Rev Offset - Vending	(954)	2	3
4	AL/IL Housekeeping	(246,750)	3	4
5	Rev Offset - Housekeeping	(17,147)	3	5
6	Rev Offset - Housekeeping	(600)	3	6
7	Rev Offset - Laundry	(13,982)	4	7
8	AL/IL Heat & Other Utilities	(424,914)	5	8
9	Rev Offset - Miscellaneous Services	(2,070)	6	9
10	Rev Offset - Repairs/Upgrades	(1,685)	6	10
11	AL/IL Maintenance	(391,498)	6	11
12	Rev Offset - Medical Records	(224)	10	12
13	AL/IL Transportation	(21,392)	14	13
14	Rev Offset - Transportation	(14,332)	14	14
15	AL/IL Administrator	(76,503)	17	15
16	AL/IL Professional Services	(71,732)	19	16
17	Unallowable Legal	(21,576)	19	17
18	AL/IL Dues, Fees, Subscriptions	(14,247)	20	18
19	Lobbying Expenses	(3,386)	20	19
20	AL/IL Office & Clerical	(482,299)	21	20
21	Penalties & Fines	(415)	21	21
22	Rev Offset - Telephone	(68,351)	21	22
23	Rev Offset - WIFI to the extent of exp	(10,521)	21	23
24	Music Fund Expenses	(8)	21	24
25	Library Fund Expenses	(1,889)	21	25
26	Rev Offset - Other Miscellaneous	(21,915)	21	26
27	Marketing Employee Benefits	(50,098)	22	27
28	AL/IL Specific Employee Benefits	(68,445)	22	28
29	AL/IL Allocated Employee Benefits	(360,837)	22	29
30	AL/IL Inservice	0	23	30
31	AL/IL Travel & Seminar	(12,070)	24	31
32	Unallowable Travel Expenses	(2,119)	24	32

33	AL/IL Other Admin Travel Expenses	(75)	25	33
34	AL/IL Insurance	(169,631)	26	34
35	AL/IL Equip Depreciation Expense	(2,269,688)	30	35
36	AL/IL Equip Rental	(13,067)	35	36
37	Unallowable Interest Expense (Investment Fees)	(44,635)	36	37
38	AL/IL Other Ownership	(2,299)	36	38
39	AL/IL Specific Expenses	(286,753)	43	39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,181,474)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	(596,282)	0	0	0	0	0	0	0	0	0	0	(596,282)	1
2	Food Purchase	(452,977)	0	0	0	0	0	0	0	0	0	0	(452,977)	2
3	Housekeeping	(291,216)	0	0	0	0	0	0	0	0	0	0	(291,216)	3
4	Laundry	(13,982)	0	0	0	0	0	0	0	0	0	0	(13,982)	4
5	Heat and Other Utilities	(461,039)	0	0	0	0	0	0	0	0	0	0	(461,039)	5
6	Maintenance	(395,253)	0	0	0	0	0	0	0	0	0	0	(395,253)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,210,749)	0	(2,210,749)	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	(224)	0	0	0	0	0	0	0	0	0	0	(224)	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	(35,724)	0	0	0	0	0	0	0	0	0	0	(35,724)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(35,948)	0	(35,948)	16									
	C. General Administration													
17	Administrative	(76,503)	0	0	0	0	0	0	0	0	0	0	(76,503)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(93,308)	0	0	0	0	0	0	0	0	0	0	(93,308)	19
20	Fees, Subscriptions & Promotions	(17,633)	0	0	0	0	0	0	0	0	0	0	(17,633)	20
21	Clerical & General Office Expenses	(621,399)	0	0	0	0	0	0	0	0	0	0	(621,399)	21
22	Employee Benefits & Payroll Taxes	(479,380)	0	0	0	0	0	0	0	0	0	0	(479,380)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(14,189)	0	0	0	0	0	0	0	0	0	0	(14,189)	24
25	Other Admin. Staff Transportation	(75)	0	0	0	0	0	0	0	0	0	0	(75)	25
26	Insurance-Prop.Liab.Malpractice	(169,631)	0	0	0	0	0	0	0	0	0	0	(169,631)	26
27	Other (specify):*	(69,373)	0	0	0	0	0	0	0	0	0	0	(69,373)	27
28	TOTAL General Administration	(1,541,491)	0	(1,541,491)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,788,188)	0	(3,788,188)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

7/1/2012 Ending:

6/30/2013

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	(2,269,688)	0	0	0	0	0	0	0	0	0	0	(2,269,688)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,863,898)	0	0	0	0	0	0	0	0	0	0	(1,863,898)	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	(13,067)	0	0	0	0	0	0	0	0	0	0	(13,067)	35
36	Other (specify):*	(46,934)	0	0	0	0	0	0	0	0	0	0	(46,934)	36
37	TOTAL Ownership	(4,193,587)	0	0	0	0	0	0	0	0	0	0	(4,193,587)	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):*	(1,179,629)	0	0	0	0	0	0	0	0	0	0	(1,179,629)	43
44	TOTAL Special Cost Centers	(1,179,629)	0	0	0	0	0	0	0	0	0	0	(1,179,629)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(9,161,404)	0	0	0	0	0	0	0	0	0	0	(9,161,404)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	N/A	N/A	Hyde Park Home Care	Hyde Park	Home Health Agency

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

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

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

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

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	None								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

7/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Montgomery Place Assisted & Independent Living
 Street Address 5550 Shouth Shore Drive
 City / State / Zip Code Chicago, IL 60637
 Phone Number (773) 753-4100
 Fax Number (773) 752-0056

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Meals	105,554	2	\$ 940,525	\$ 810,879	38,634	\$ 344,243	1
2	2	Food	Meals	105,554	2	626,328	38,634	38,634	229,243	2
3	3	Housekeeping	Square Feet	203,488	2	253,995	243,523	5,804	7,245	3
4	5	Utilities	Square Feet	203,488	2	437,389	5,804	5,804	12,475	4
5	6	Maintenance	Revenue	12,000,262	2	622,574	293,457	4,454,043	231,076	5
6	14	Program Transportation	Revenue	12,000,262	2	34,018	44,525	4,454,043	12,626	6
7	17	Administrative	Revenue	12,000,262	2	121,658	121,658	4,454,043	45,155	7
8	19	Professional Fees	Revenue	12,000,262	2	114,072		4,454,043	42,339	8
9	20	Dues and Subscriptions	Revenue	12,000,262	2	22,656		4,454,043	8,409	9
10	21	Clerical & General Office	Revenue	12,000,262	2	766,968	894,859	4,454,043	284,669	10
11	22	Employee Benefits	Salary	4,313,032	2	796,970		2,360,261	436,133	11
12	24	Travel & Seminar	Revenue	12,000,262	2	19,194		4,454,043	7,124	12
13	25	Other Admin. Staff Transportatio	Revenue	12,000,262	2	119		4,454,043	44	13
14	26	Insurance	Square Feet	203,488	2	174,611		5,804	4,980	14
15	30	Depreciation	Actual	2,686,558	2	2,686,558		416,870	416,870	15
16	32	Interest	Square Feet	203,488	2	1,907,862		5,804	54,417	16
17	35	Equipment Rental	Revenue	12,000,262	2	20,779		4,454,043	7,712	17
18	36	Other Ownership	Revenue	12,000,262	2	3,656		4,454,043	1,357	18
19	4	Laundry	Actual	59,759	1	59,759	53,006	59,759	59,759	19
20	9	Medical Director	Actual	26,091	1	26,091		26,091	26,091	20
21	10	Nursing/Medical Records	Actual	1,416,677	1	1,416,677	1,337,158	1,416,677	1,416,677	21
22	10A	Therapy	Actual	646,910	1	646,910		646,910	646,910	22
23	11	Activities	Actual	102,527	1	102,527	88,193	102,527	102,527	23
24	12	Social Services	Actual	76,089	1	76,089	75,428	76,089	76,089	24
25	TOTALS					\$ 11,877,984	\$ 3,962,686		\$ 4,474,170	25

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 7/1/2012

Ending: 7/30/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Montgomery Place Assisted & Independent Living
 Street Address 5550 Shouth Shore Drive
 City / State / Zip Code Chicago, IL 60637
 Phone Number (773) 753-4100
 Fax Number (773) 752-0056

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Carry Forward PG8 Totals				\$ 11,877,984	\$ 3,962,686		\$ 4,474,170	1
2	39 Ancillary	Actual	171,980	1	171,980		171,980	171,980	2
3	42 Provider Participation Fee	Actual	98,631	1	98,631		98,631	98,631	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	TOTALS				\$ 12,148,595	\$ 3,962,686		\$ 4,744,781	25

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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	Facility (revenue bonds)	N/A	11/20/06	\$ 40,850,000	\$ 32,740,000	5/15/2038	5.4940	\$ 1,918,315	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 40,850,000	\$ 32,740,000			\$ 1,918,315	9					
B. Non-Facility Related*																	
10	Remove AL/IL portion of interest expense										(1,853,445)	10					
11	Interest income offset (PG5, Line 10)										(10,453)	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (1,863,898)	14					
15	TOTALS (line 9+line14)						\$ 40,850,000	\$ 32,740,000			\$ 54,417	15					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008 _____	8	FOR BHF USE ONLY		
	2009 _____	9			
	2010 _____	10			
	2011 _____	11			
	2012 _____	12			
			13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Fred Saviano, CFO

TELEPHONE (773) 753-4100 FAX #: (773) 752-0056

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	N/A	N/A	\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning:

7/1/2012 Ending:

6/30/2013

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 Assisted Living, 14,833 Square Feet, 22 Units

Montgomery Place Retirement Community Independent Living, 182,851 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:

A. Land.

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Various		1997	20,111		20			
10	Various		1998	19,268		20			
11	Various		1999	40,652		20			
12	Various		2000	143,621		20			
13	Various		2001	117,397		20			
14	Various		2002	68,258		20			
15	Various		2003	95,898		20			
16	Various		2004	76,985		20			
17	Various		2005	7,058		20			
18	Various		2006	14,779		20			
19	Various		2007	12,137		20			
20	Elevator		2008	3,481		20			
21	Building canopy & facade		2009	5,788		20			
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	<u>Carpeting</u>	<u>2010</u>	\$ <u>910</u>	\$	<u>20</u>	\$	\$	\$	37
38	<u>Carpeting</u>	<u>2012</u>	<u>1,193</u>		<u>20</u>				38
39	<u>Elevator cabinet</u>	<u>2012</u>	<u>56</u>		<u>20</u>				39
40	<u>Elevator control repair</u>	<u>2013</u>	<u>106</u>		<u>20</u>				40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Total nursing facility building depreciation expense and accumulated depreciation			306,565		306,565		3,885,258	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,363,439	\$ 306,565		\$ 306,565	\$	\$ 3,885,258	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,224,908	\$ 109,041	\$ 109,041	\$	10	\$ 396,737	71
72	Current Year Purchases	12,639	1,264	1,264		10	1,264	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,237,547	\$ 110,305	\$ 110,305	\$		\$ 398,001	75

D. Vehicle Costs. (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	\$ 1,382	76
77	Facility	2005 Glaval Universal Bus	2004	12,922				5	12,922	77
78	Facility	Auto	2007	4,110				5	4,110	78
79										79
80	TOTALS			\$ 18,414	\$	\$	\$		\$ 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)	\$ 8,510,825	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 416,870	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 416,870	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)	\$ 4,301,673	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	Assisted & Independent Living	\$ 46,708,601	\$ 2,269,688	\$ 23,204,596	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 46,708,601	\$ 2,269,688	\$ 23,204,596	91

G. Construction-in-Progress

	Description	Cost	
92	Upgrades to building	\$ 323,302	92
93			93
94			94
95		\$ 323,302	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: 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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 20,779 Description: Copiers \$17,863 and Postage Machine \$2,916

(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>Not applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2012 Ending: 6/30/2013
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A.3	hrs	\$	6,583	\$ 215,952	\$ 949	6,583	\$ 216,901	1	
2	Licensed Speech and Language Development Therapist	10A.3	hrs		232	15,402		232	15,402	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A.3	hrs		10,959	413,651	956	10,959	414,607	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			\$	17,774	\$ 645,005	\$ 1,905	17,774	\$ 646,910	14	

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

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 7/1/2012

Ending:

6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2013

(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	\$ 160,781	\$	1
2	Cash-Patient Deposits	3,157,469		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (17,567))	376,956		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,689		6
7	Other Prepaid Expenses	70,191		7
8	Accounts Receivable (owners or related parties)	194,171		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,000,257	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,263,377		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	47,370,221		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,595,593		16
17	Accumulated Depreciation (book methods)	(27,506,269)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec CIP)	323,302		22
23	Other(specify): <u>See Supplemental Schedule</u>	8,928,349		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,228,185	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 49,228,442	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 572,265	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	556,682		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Liabilities</u>	586,779		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,715,726	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	32,740,000		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Original Bond Issue, net</u>	460,447		43
44	<u>See Supplemental Schedule</u>	22,324,453		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 55,524,900	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 57,240,626	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (8,012,184)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 49,228,442	\$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

<u>Line 23 - Other Long-Term Assets</u>		<u>Line 44 - Other Long-term Liabilities</u>	
<u>Description</u>	<u>Amount</u>	<u>Description</u>	<u>Amount</u>
Assets limited as to use - Bond funds	\$ 7,949,722	Due to affiliate - Church Home	\$ 2,786,326
Bond financing costs, net	927,903	Refundable entrance fees, net of amortization	17,795,653
Assets limited as to use - donor restricted	50,724	Nonrefundable entrance fees, net of amortization	1,742,474
	<u>\$ 8,928,349</u>		<u>#####</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,211,082)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,211,082)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(801,305)	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)	\$ (801,305)	17
	B. Transfers (Itemize):		
18	Less Temporarily Restricted FYE 06/30/2012	(58,523)	18
19	Temporarily Restricted FYE 06/30/2013	58,726	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 203	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (8,012,184)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 7/1/2012Ending: 6/30/2013

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,350,998	1
2	Discounts and Allowances for all Levels	(1,648,064)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,702,934	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,182,810	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,182,810	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	10,104	13
14	Non-Patient Meals	54,938	14
15	Telephone, Television and Radio	68,351	15
16	Rental of Facility Space	26,719	16
17	Sale of Drugs	147,028	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,959	19
20	Radiology and X-Ray	5,195	20
21	Other Medical Services	153,032	21
22	Laundry	13,982	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 513,308	23
D. Non-Operating Revenue			
24	Contributions	125,885	24
25	Interest and Other Investment Income***	690,516	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 816,401	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	7,889,427	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,889,427	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,104,880	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,094,582	31
32	Health Care	2,316,868	32
33	General Administration	2,374,208	33
B. Capital Expense			
34	Ownership	4,670,287	34
C. Ancillary Expense			
35	Special Cost Centers	1,351,609	35
36	Provider Participation Fee	98,631	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,906,185	40
41	Income before Income Taxes (line 30 minus line 40)**	(801,305)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (801,305)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 171,962	44
45	Private Pay - Net Inpatient Revenue	1,601,931	45
46	Medicare - Net Inpatient Revenue	882,482	46
47	Other-(specify) <u>Hospice</u>	31,046	47
48	Other-(specify) <u>Private Insurance</u>	15,513	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,702,934	49

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

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

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

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

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	1,872	2,652	\$ 168,979	\$ 63.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,741	7,635	254,696	33.36	3
4	Licensed Practical Nurses	15,886	16,639	406,534	24.43	4
5	CNAs & Orderlies	53,002	54,432	394,716	7.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,045	44,870	21.94	9
10	Activity Assistants	4,666	4,493	43,323	9.64	10
11	Social Service Workers	1,954	1,085	19,286	17.78	11
12	Dietician	72	60	1,048	17.47	12
13	Food Service Supervisor	4,798	4,328	104,040	24.04	13
14	Head Cook	1,712	1,446	41,600	28.77	14
15	Cook Helpers/Assistants	55,855	50,141	560,343	11.18	15
16	Dishwashers	11,725	10,532	103,849	9.86	16
17	Maintenance Workers	7,648	7,623	163,536	21.45	17
18	Housekeepers	26,003	25,233	243,523	9.65	18
19	Laundry	5,332	4,894	53,006	10.83	19
20	Administrator	1,856	2,159	121,658	56.35	20
21	Assistant Administrator					21
22	Other Administrative	12,039	12,010	559,708	46.60	22
23	Office Manager	6,137	5,904	121,828	20.63	23
24	Clerical	1,899	1,955	91,664	46.89	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	2,113	2,167	42,080	19.42	31
32	Other Health C: See supplemental s	2,172	2,313	70,153	30.33	32
33	Other(specify) See supplemental s	50,336	48,275	702,591	14.55	33
34	TOTAL (lines 1 - 33)	277,850	268,021	\$ 4,313,032 *	\$ 16.09	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	237	\$ 11,866	1.2	35
36	Medical Director	240	26,091	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	67	2,336	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	31	1,074	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	\$ 41,367		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

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - Line 32 Other Health Care

	1	2**	3	4
	# of Hrs.	# of Hrs.	Reporting Period	Average
Description	Actually	Paid and	Total Salaries,	Hourly
	Worked	Accrued	Wages	Wage
32 A MDS Coordinator	2,172	2,313	\$ 70,153	\$ 30.33
Total Line 32	2,172	2,313	\$ 70,153	\$ 30.33

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - Line 33 Other

	1	2**	3	4
	# of Hrs.	# of Hrs.	Reporting Period	Average
Description	Actually	Paid and	Total Salaries,	Hourly
	Worked	Accrued	Wages	Wage
33 A Marketing	6,494	6,865	\$ 233,442	\$ 34.00
33 B Pastorial Care	2,016	1,139	56,142	49.29
33 C Transportation	3,701	3,538	44,525	12.58
33 D Security	14,619	14,307	129,921	9.08
33 E Activity Director - IL	2,020	1,835	44,388	24.19
33 F Assisted Living	21,486	20,591	194,173	9.43
Total Line 33	50,336	48,275	\$ 702,591	\$ 14.55

STATE OF ILLINOIS

Facility Name & ID Number

Montgomery Place

0037515

Report Period Beginning: 7/1/2012

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

Inv #	Date	GL Acct.	Payee/Vendor	Amount	
1776696	7/10/2012	5446-10-2010	Duane Morris	\$ 282.90	Employment matters
1787184	8/16/2012	5446-10-2010	Duane Morris	188.00	Employment matters
1796190	9/19/2012	5446-10-2010	Duane Morris	404.00	General facility matters - annual financial aud
1796191	9/19/2012	5446-10-2010	Duane Morris	2,726.00	Employment matters
1813414	11/20/2012	5446-10-2010	Duane Morris	564.00	Employment matters
1813415	11/20/2012	5446-10-2010	Duane Morris	158.50	General facility matters - annual life safety co
1820499	12/13/2012	5446-10-2010	Duane Morris	47.00	Employment matters
1825574	1/11/2013	5446-10-2010	Duane Morris	376.00	Employment matters
1825575	1/11/2013	5446-10-2010	Duane Morris	505.00	General facility matters - annual life safety co
1832971	2/7/2013	5446-10-2010	Duane Morris	445.50	Employment matters
1845365	3/18/2013	5446-10-2010	Duane Morris	198.00	Employment matters
			Total Invoices - Duane Morris	5,894.90	
CHI1517446	8/6/2012	5446-10-2010	Veritext National Deposition & Litigation Services	912.00	Corrales, Montefrio v. Montgomery Place, Inc
			Veritext National Deposition & Litigation Serv	912.00	
1711873	9/20/2012	5446-10-2010	Schiff Hardin LLP	350.00	General facility matters - annual financial aud
1735231	1/8/2013	5446-10-2010	Schiff Hardin LLP	256.00	General facility matters
1745446	1/11/2013	5446-10-2010	Schiff Hardin LLP	574.50	General facility matters - resident related
			Total Invoices - Schiff Hardin LLP	1,180.50	
8212826	7/31/2012	5446-10-2010	Ungaretti & Harris	375.00	General facility matters - resident handbook
8214589	9/30/2012	5446-10-2010	Ungaretti & Harris	245.00	General facility matters - UCC continuation
8215133	10/31/2012	5446-10-2010	Ungaretti & Harris	243.75	General facility matters - annual financial aud
8216332	11/30/2012	5446-10-2010	Ungaretti & Harris	1,347.50	General facility matters - resident related
8216894	12/31/2012	5446-10-2010	Ungaretti & Harris	2,021.25	General facility matters - resident related
8218279	1/31/2013	5446-10-2010	Ungaretti & Harris	2,021.25	General facility matters - resident related
8218688	2/28/2013	5446-10-2010	Ungaretti & Harris	1,091.25	General facility matters - resident related
8219526	3/31/2013	5446-10-2010	Ungaretti & Harris	2,190.00	General facility matters - resident related
8220931	4/30/2013	5446-10-2010	Ungaretti & Harris	1,398.75	General facility matters - resident related
8221869	5/31/2013	5446-10-2010	Ungaretti & Harris	4,951.25	General facility matters - resident related
8222405	6/30/2013	5446-10-2010	Ungaretti & Harris	5,254.10	General facility matters - resident related

			Total Invoices - Ungaretti & Harris	21,139.10	
943981	1/28/2013	5446-10-2010	Polsinelli Shughart PC	430.00	General facility matters - survey findings
958785	4/1/2013	5446-10-2010	Polsinelli Shughart PC	129.00	General facility matters - resident related
			Total Invoices - Polsinelli Shughart PC	559.00	
			Accrued EEOC Settlement	15,000.00	
			Accrued Legal Expenses	6,576.75	

Total Legal Invoices (rounded)	\$ 51,262	[A]
Unallowable legal expenses	(21,577)	
Net Legal Services	\$ 29,685	
Total Legal Expenses per General Ledger	\$ 51,262	[B]
Variance	\$ -	[A] - [B]

	-
	-
	15,000.00
	6,576.75
Total Unallowable Legal Expenses (rounded)	\$ 21,577

STATE OF ILLINOIS

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

7/1/2012

Ending:

6/30/2013

Date	Payee	Topic	Attendee	Job Class	Location
6/20/2013	Life Services Network	Impact of the acctg standards update on acctg for entr fees, im	Fred Saviano	Management	Orland Park, Illinois
6/20/2013	Life Services Network	of health care reform on employees, transition to higher levels c	Richard Santiago	Finance	Orland Park, Illinois
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Gilda Mathis	Activities HC	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Lorri Colbert	Administration	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Demetris Franklin	Administration	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Rebecca Reif	Catered Living	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Richard Santiago	Finance	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Sandra Paraf	Finance	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Holly Pawlak	Food Services	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Laura Gabbert	Food Services	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Marie Roger	Housekeeping	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	William Jansa	Maintenance	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Michael Apa	Management	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Mary VonGoeben	Management	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Fred Saviano	Management	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Beverly Covington	Nursing	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Monica Stout	Nursing	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Sharon Green	Nursing	Chicago, Il
5/1/13-5/3/13	NIU Outreach	LSN Annual Conference	Latticia Williams	Social Services	Chicago, Il
2/27/2013	Employment law webinar	Wage and Hour Internal Audit	Elaine Ayot	Finance	Chicago, Il
10/3/2012	Activity Connection	Dementia Training	Gilda Mathis	Activities HC	Chicago, Il
10/19/2012	American Associaton of Nurses	Resident Assessment Coordinator Certified	Beverly Covington	Nursing	Chicago, Il
10/19/2012	American Associaton of Nurses	Resident Assessment Coordinator Certified	Sharon Green	Nursing	Chicago, Il
6/6/13 & 6/13/13	Illinois Food Retailers Association	Illinois Food Safety and Sanitation	Laura Gabbert	Food Services	Skokie, Il
3/21/2013	Fred Pryor	Training Rewards renewal	Elaine Ayot	Finance	Chicago, Il
9/30/2012	Dementia training		Rebecca Reif	Catered Living	Chicago, Il
		Total Illinois or within 50 miles of Illinois seminar expenses			
		In-State Travel			
11/28/12-11/30/12	International Council on Active Aging	International Council on Active Aging	Gilda Mathis	Activites HC	Vancouver, BC
10/21/12-10/24/12	Leading Age Meeting	AHSA -Leading Age Registration	Michael Apa	Management	Denver, Colorado
10/21/12-10/24/12	Leading Age Meeting	AHSA -Leading Age Registration	Fred Saviano	Finance	Denver, Colorado

10/21/12-10/24/12	Leading Age Meeting	AHSA -Leading Age Registration	Mary VonGoeben	Management	Denver, Colorado
10/21/12-10/24/12	Leading Age Meeting	AHSA -Leading Age Registration	Susan Levy	Board member	Denver, Colorado
		Total out-of-area seminar expenses			
		Out-of-State Travel			
	Less Allocated Assisted/Independent Living Expenses				
Net Expenses - Schedule 5, Line 24, Column 8					

766
766
3,503
10,812
(12,070)
7,124

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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Montgomery Place# 0037515Report Period Beginning: 7/1/2012Ending: 6/30/2013**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? Yes
If YES, give association name and amount. Life Services Network \$5,345, LeadingAge \$3,970
- (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 - 20
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,084 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. \$ 98,631
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 (AL/IL) 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. \$ 1,559
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes - See Seminar Schedule
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? 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.