

Facility Name & ID Number MONTGOMERY TERRACE

0047001 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,375			5,375	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,375			5,375	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.79%

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

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

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

NONE

F. Does the facility maintain a daily midnight census?

YES

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

YES NO

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

YES NO

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

Date started MARCH 11, 1987

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

YES Date 03/11/1987 NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2016 Fiscal Year: N/A

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

Facility Name & ID Number **MONTGOMERY TERRACE** # **0047001** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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	15,730	541	1,240	17,511		17,511		17,511		1
2	Food Purchase		26,688		26,688		26,688	(267)	26,421		2
3	Housekeeping	3,584	2,350		5,934		5,934		5,934		3
4	Laundry		475		475		475		475		4
5	Heat and Other Utilities			14,741	14,741		14,741	135	14,876		5
6	Maintenance	7,298	1,187	5,995	14,480		14,480	60	14,540		6
7	Other (specify):*										7
8	TOTAL General Services	26,612	31,241	21,976	79,829		79,829	(72)	79,757		8
	B. Health Care and Programs										
9	Medical Director			5,200	5,200		5,200		5,200		9
10	Nursing and Medical Records	144,235	54	7,408	151,697	(2,218)	149,479		149,479		10
10a	Therapy										10a
11	Activities	17,581	676	1,200	19,457		19,457		19,457		11
12	Social Services										12
13	CNA Training		67		67	2,218	2,285		2,285		13
14	Program Transportation			4,199	4,199		4,199		4,199		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	161,816	797	18,007	180,620		180,620		180,620		16
	C. General Administration										
17	Administrative	43,450			43,450		43,450		43,450		17
18	Directors Fees										18
19	Professional Services			2,887	2,887		2,887		2,887		19
20	Dues, Fees, Subscriptions & Promotions			984	984		984		984		20
21	Clerical & General Office Expenses	1,609	741	24,459	26,809		26,809	(18,539)	8,270		21
22	Employee Benefits & Payroll Taxes			22,631	22,631		22,631		22,631		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,282	1,282		1,282		1,282		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,815	4,815		4,815		4,815		26
27	Other (specify):*										27
28	TOTAL General Administration	45,059	741	57,058	102,858		102,858	(18,539)	84,319		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	233,487	32,779	97,041	363,307		363,307	(18,611)	344,696		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 TERRACE**

#0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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			4,037	4,037		4,037	3,698	7,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			280	280		280		280			32
33	Real Estate Taxes			7,234	7,234		7,234		7,234			33
34	Rent-Facility & Grounds			52,500	52,500		52,500		52,500			34
35	Rent-Equipment & Vehicles			360	360		360		360			35
36	Other (specify):*			1,842	1,842		1,842	(1,842)				36
37	TOTAL Ownership			66,253	66,253		66,253	1,856	68,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,406	36,406		36,406		36,406			42
43	Other (specify):*		3,478		3,478		3,478	(3,478)				43
44	TOTAL Special Cost Centers		3,478	36,406	39,884		39,884	(3,478)	36,406			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	233,487	36,257	199,700	469,444		469,444	(20,233)	449,211			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,846	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(267)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,842)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule RESIDENT SUPPLIES	(3,478)	43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,741)		\$	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	(16,492)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,492)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (20,233)		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

MONTGOMERY TERRACE

ID# 0047001

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	PERSONAL SUPPLIES	\$ (3,478)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,478)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONTGOMERY TERRACE# 0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(267)	0	0	0	0	0	0	0	0	0	0	(267)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	135	0	0	0	0	0	0	0	0	0	135	5
6	Maintenance	0	60	0	0	0	0	0	0	0	0	0	60	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(267)	195	0	(72)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(18,539)	0	0	0	0	0	0	0	0	0	(18,539)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(18,539)	0	(18,539)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(267)	(18,344)	0	(18,611)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONTGOMERY TERRACE# 0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	1,846	1,852	0	0	0	0	0	0	0	0	0	3,698	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,842)	0	0	0	0	0	0	0	0	0	0	(1,842)	36
37	TOTAL Ownership	4	1,852	0	1,856	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):*	(3,478)	0	0	0	0	0	0	0	0	0	0	(3,478)	43
44	TOTAL Special Cost Centers	(3,478)	0	0	0	0	0	0	0	0	0	0	(3,478)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,741)	(16,492)	0	(20,233)	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
ANGELA BARR-CORNELL	100%	SOUTH SIDE MANOR	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	MONTGOMERY TERRACE	NOKOMIS	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	JAMES R THOMPSON HOUSE	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	LINCOLN HOUSE	LINCOLN	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	EAST SIDE TERRACE	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	WINETKA HOUSE	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE
ANGELA BARR-CORNELL	100%	SERENITY HOUSE	LINCOLN	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE

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	21	CENTRAL OFFICE	\$ 20,197	ANGELA BARR-CORNELL	100.00%	\$	(20,197)	1
2	V	5	C.O UTILITIES				135	135	2
3	V	6	C.O. MAINTENANCE				60	60	3
4	V	21	C.O OFFICE SUPPLIES				1,658	1,658	4
5	V	30	C.O. DEPRECIATION EXPENSE				1,852	1,852	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		\$ 20,197				\$ 3,705	\$ * (16,492)	14

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

Facility Name & ID Number

MONTGOMERY TERRACE

0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ANGELA BARR-CORNELL	100%	CORMAN HOUSE	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE	1
2	ANGELA BARR-CORNELL	100%	ROCHELLE HOUSE	LINCOLN	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE	2
3	ANGELA BARR-CORNELL	100%	WESTERN HOUSE	DECATUR	ALPHA OMEGA	OVIEDO, FL	CENTRAL OFFICE	3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

MONTGOMERY TERRACE

0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ANGELA BARR-CORNELL	OWNER	ADMIN-MGMT	100.00	96,298	6	15.00	Admin-Mgmt	\$ 27,728	17-1	1
2	JASON CORNELL	SON OF OWNER	ADMIN-MGMT		33,617	6	15.00	Admin-Mgmt	9,535	17-1	2
3	CARA EBBELER	DAUGHTER OF OW	ADMIN-CLERICAL			8	2.60	Admin-Clerical	4,008	17-1	3
4	CARA EBBELER	DAUGHTER OF OW	CONSULTANT		4,800	8	17.40	Consultant	1,200	11-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,471		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 TERRACE

0047001

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

ANGELA BARR-CORNELL

Street Address

80 ELLINGTON PLACE

City / State / Zip Code

OVIDO, FL 32765

Phone Number

()

Fax Number

()

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
2									2
3									3
4									4
5									5
6									6
7		<u>SEE ATTACHED</u>							7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

MONTGOMERY TERRACE

0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	11											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
A. Directly Facility Related																					
Long-Term																					
1	HICKORY STATE BANK		X	PURCHASE VAN	\$335.09	07/30/2014	\$ 18,982	\$ 10,398	08/13/19	2.2500	\$ 280	1									
2												2									
3												3									
4												4									
5												5									
Working Capital																					
6												6									
7												7									
8												8									
9	TOTAL Facility Related				\$335.09		\$ 18,982	\$ 10,398			\$ 280	9									
B. Non-Facility Related*																					
10												10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$	14									
15	TOTALS (line 9+line14)						\$ 18,982	\$ 10,398			\$ 280	15									

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

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

** 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 2015 report.		\$	7,300	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.)		\$	7,234	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(66)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	7,300	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.		\$	7,234	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	9,466	8
	2012	9,392	9
	2013	9,465	10
	2014	7,248	11
	2015	7,234	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONTGOMERY TERRACE COUNTY MONTGOMERY

FACILITY IDPH LICENSE NUMBER 0047001

CONTACT PERSON REGARDING THIS REPORT ANGELA BARR-CORNELL

TELEPHONE (409) 766-1759 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-22-276-004</u>	<u>NURSING FACILITY</u>	\$ <u>7,234.42</u>	\$ <u>7,234.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>7,234.42</u></u>	\$ <u><u>7,234.42</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number MONTGOMERY TERRACE

0047001

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,030 B. General Construction Type: Exterior BRICK/VINYL Frame WOOD/GYPSUM BO Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

Blank lines for listing other business entities.

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 2 contains 'N/A' and row 3 contains '#VALUE!'.

Facility Name & ID Number MONTGOMERY TERRACE

0047001

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SPRINKLER CHANGES	1987		575		10			575	9
10		STORAGE SHED	1987		509		10			509	10
11		FIRE ALARM REPARIS	1989		810		10			810	11
12		LANDSCAPING	1990		850		20			850	12
13		CARPET	1992		3,597		10			3,597	13
14		GILLEN PROPERTIS	1993		500		10			500	14
15		WALLPAPER	1995		372		10			372	15
16		FLOORING	1996		818		10			818	16
17		AIR CONDITIONING	1996		1,396		10			1,396	17
18		CARPETING/FLOORING	1997		2,731		20	137	137	2,731	18
19		WINDOW AIR CONDITIONER	1998		1,647		10			1,647	19
20		DECK	2001		4,735	140	20	237	97	4,735	20
21		CERAMIC TILE	2003		3,963	164	20	198	35	3,718	21
22		RESURFACE PARKING LOT	2003		1,995	59	20	100	41	1,907	22
23		BATHROOM IMPROVEMENTS	2004		1,356		10	90	90	1,356	23
24		INTERIOR PAINTING	2005		1,895	112	20	95	(17)	1,504	24
25		BATHROOM FLOOR	2005		1,085	64	20	54	(10)	861	25
26		WATER TEMP REGULATOR	2005		1,440	85	20	72	(13)	1,143	26
27		SPRINKLER SYSTEM REPAIR	2006		1,210		10	40	40	1,210	27
28		AUTOMATIC DOOR CLOSURE	2006		1,108		10	91	91	1,108	28
29		SEWER WORK	2007		4,248		20	212	212	4,248	29
30		ROOF	2008		9,310	339	27.5	339		2,724	30
31		REPAVE DRIVEWAY	2008		1,650	60	27.5	60		487	31
32		WATER HEATER	2010		493		20	25	25	493	32
33		WATER HEATER	2010		795		20	40	40	795	33
34		SHOWER INSTALLATION	2016		4,650	35	27.5		(35)	35	34
35											35
36		CENTRAL OFFICE						1,852	1,852		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 TERRACE**

0047001

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			53,738	1,057	3,641	2,585	40,129	

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	18,368		297	297	10	18,368	73
74								74
75	TOTALS	\$ 18,368	\$	\$ 297	\$ 297		\$ 18,368	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	Transportation	2012 Dodge Grand Caravan	2014	\$ 18,984	\$ 2,980	\$ 3,797	\$ 817	5	\$ 11,406	76
77										77
78										78
79										79
80	TOTALS			\$ 18,984	\$ 2,980	\$ 3,797	\$ 817		\$ 11,406	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)	\$ 91,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 7,735	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,698	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 69,903	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FLORA BANK & TRUST

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1987</u>	<u>16</u>	<u>01/12/1987</u>	\$ <u>52,500</u>			3
4	Additions							4
5								5
6								6
7	TOTAL		16		\$ 52,500			7

10. Effective dates of current rental agreement:

Beginning 03/06/2013

Ending 03/06/2018

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2017</u>	\$ <u>52,500</u>
13.	<u>12/31/2018</u>	\$ <u>52,500</u>
14.	<u>12/31/2019</u>	\$ <u>52,500</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>General - Maintenance</u>	<u>2005 Ford F150</u>	\$ <u>30.00</u>	\$ <u>360</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 30.00	\$ 360	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		67		67
3	Classroom Wages (a)		330		330
4	Clinical Wages (b)		660		660
5	In-House Trainer Wages (c)		1,228		1,228
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,285	\$	\$ 2,285
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,285		

C. CONTRACTUAL INCOME

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

\$ 2,576

D. NUMBER OF CNAs TRAINED

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2016**

(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	\$ 13,546	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	37,293		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 50,839	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	53,738		15
16	Equipment, at Historical Cost	37,352		16
17	Accumulated Depreciation (book methods)	(69,903)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,187	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 72,026	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,051	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,826		29
30	Accrued Salaries Payable	3,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	360		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,842		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 25,917	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,571		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,571	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 32,489	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 39,537	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 72,026	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 23,636	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 23,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,990	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	(28,963)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) INTERCOMPAMY	(101,126)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 15,901	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)	\$ 39,537	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MONTGOMERY TERRACE

0047001

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	\$ 614,074	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 614,074	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,576	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,576	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	103	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 103	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER	(1,319)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,319)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 615,434	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	79,829	31
32	Health Care	180,620	32
33	General Administration	102,858	33
B. Capital Expense			
34	Ownership	66,253	34
C. Ancillary Expense			
35	Special Cost Centers	3,478	35
36	Provider Participation Fee	36,406	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 469,444	40
41	Income before Income Taxes (line 30 minus line 40)**	145,990	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 145,990	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 474,051	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) INCOME CREDITS	17,272	47
48	Other-(specify) SOCIAL SECURITY	122,751	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 614,074	49

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

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

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

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

Facility Name & ID Number MONTGOMERY TERRACE

0047001

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses	272	9,999	36.76	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies	9,882	10,463	9.18	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,863	1,863	9.44	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	1,686	1,686	9.33	15
16	Dishwashers				16
17	Maintenance Workers	384	416	17.54	17
18	Housekeepers	441	441	8.13	18
19	Laundry				19
20	Administrator	720	720	60.35	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	260	260	6.19	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	2,258	2,386	16.02	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	17,766	18,507	\$ 233,487 *	\$ 12.62 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	24	\$ 1,240	1-3 35
36	Medical Director	MO FEE	5,200	9-3 36
37	Medical Records Consultant		100	10-3 37
38	Nurse Consultant	162	4,920	10-3 38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	32	1,200	11-3 44
45	Social Service Consultant			45
46	Other(specify) <u>DENTAL</u>	PER VISIT	1,408	10-3 46
47	<u>PYSC</u>	MO FEE	1,050	10-3 47
48	<u>EYE EXAM</u>	PER VISIT	30	10-3 48
49	TOTAL (lines 35 - 48)	218	\$ 15,148	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ANGELA BARR-CORNELL	ADMIN	100	\$ 27,728	Workers' Compensation Insurance	\$ 7,220	IDPH License Fee	\$	
ANNA BRACKENBUSH	ADMIN		2,179	Unemployment Compensation Insurance	2,077	Advertising: Employee Recruitment	680	
JASON CORNELL	ADMIN		9,535	FICA Taxes	17,656	Health Care Worker Background Check	31	
CARA EBBELER	ADMIN		4,008	Employee Health Insurance		(Indicate # of checks performed <u>1</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		VEHICLE LICENSE	116	
				SIMPLE IRA	(4,322)	DUES & SUBSCRIPTIONS	157	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 43,450					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Larsson Woodyard & Henson LLP	Accounting		\$ 2,887			\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,887	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,282

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MONTGOMERY TERRACE

0047001

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,406
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ NO
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees