

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0039347</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Montgomery Nrsg & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>South Rt 127 Box 309</u> <u>Hillsboro</u> <u>62049</u>																									
Number City Zip Code																									
County: <u>Montgomery</u>																									
Telephone Number: <u>(217) 532-6126</u> Fax # <u>(217) 532-9465</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>J. Terry Dooling</u></td></tr><tr><td>(Title) <u>Treasurer</u></td></tr><tr><td>(Signed) <u>See Accountant's Compilation Report</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>J. Terry Dooling</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u></td></tr><tr><td>(Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>J. Terry Dooling</u>	(Title) <u>Treasurer</u>	(Signed) <u>See Accountant's Compilation Report</u>	Paid Preparer	(Print Name and Title) <u>J. Terry Dooling</u> <u>Partner</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 E. Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618)465-7717</u> Fax # <u>(618)465-7710</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>04/01/1994</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>J. Terry Dooling</u> Telephone Number: <u>(618) 465-7717</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr# 0039347 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>22</u>	Skilled (SNF)	<u>22</u>	<u>8,052</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>88</u>	Intermediate (ICF)	<u>88</u>	<u>32,208</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,260</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14</u>	<u>387</u>	<u>4,161</u>	<u>4,562</u>	8
9	SNF/PED					9
10	ICF	<u>17,612</u>	<u>13,268</u>	<u>274</u>	<u>31,154</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,626</u>	<u>13,655</u>	<u>4,435</u>	<u>35,716</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.71%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

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

YES ☐NO ☒

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

Date started 04/01/1994

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

YES ☒Date 04/01/1994NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 20 and days of care provided 4,087Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
	A. General Services										
1	Dietary	255,956	15,586	6,568	278,110		278,110		278,110		1
2	Food Purchase		238,151		238,151		238,151		238,151		2
3	Housekeeping	128,950	15,773		144,723		144,723		144,723		3
4	Laundry	85,006	19,471		104,477		104,477		104,477		4
5	Heat and Other Utilities			101,860	101,860		101,860		101,860		5
6	Maintenance	55,365	7,633	57,774	120,772		120,772	535	121,307		6
7	Other (specify):* Med Waste Removal			6,816	6,816		6,816		6,816		7
8	TOTAL General Services	525,277	296,614	173,018	994,909		994,909	535	995,444		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,674,703	142,773	57,406	1,874,882	(5,760)	1,869,122		1,869,122		10
10a	Therapy										10a
11	Activities	51,507	7,939	288	59,734	123	59,857		59,857		11
12	Social Services	41,832	23	533	42,388	(123)	42,265		42,265		12
13	CNA Training			2,071	2,071	5,760	7,831		7,831		13
14	Program Transportation		8,717		8,717		8,717		8,717		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,768,042	159,452	69,898	1,997,392		1,997,392		1,997,392		16
	C. General Administration										
17	Administrative	87,639	11,121	347,158	445,918	(3,497)	442,421	(218,233)	224,188		17
18	Directors Fees										18
19	Professional Services			13,613	13,613	3,497	17,110	(358)	16,752		19
20	Dues, Fees, Subscriptions & Promotions			73,467	73,467		73,467	(48,065)	25,402		20
21	Clerical & General Office Expenses	71,744	19,400	85,303	176,447		176,447	54,594	231,041		21
22	Employee Benefits & Payroll Taxes			348,228	348,228		348,228	12,566	360,794		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,780	11,780		11,780	2,176	13,956		24
25	Other Admin. Staff Transportation							1,876	1,876		25
26	Insurance-Prop.Liab.Malpractice			61,170	61,170		61,170	1,884	63,054		26
27	Other (specify):*										27
28	TOTAL General Administration	159,383	30,521	940,719	1,130,623		1,130,623	(193,560)	937,063		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,452,702	486,587	1,183,635	4,122,924		4,122,924	(193,025)	3,929,899		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			175,235	175,235		175,235	(2,338)	172,897			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,931	148,931		148,931	(27,419)	121,512			32
33	Real Estate Taxes			49,906	49,906		49,906		49,906			33
34	Rent-Facility & Grounds							8,970	8,970			34
35	Rent-Equipment & Vehicles			6,199	6,199		6,199	2,929	9,128			35
36	Other (specify):*			19,833	19,833		19,833		19,833			36
37	TOTAL Ownership			400,104	400,104		400,104	(17,858)	382,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			903	903		903		903			38
39	Ancillary Service Centers		117,829	621,704	739,533		739,533	(33,487)	706,046			39
40	Barber and Beauty Shops		2,221		2,221		2,221		2,221			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			359,903	359,903		359,903		359,903			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		120,050	982,510	1,102,560		1,102,560	(33,487)	1,069,073			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,452,702	606,637	2,566,249	5,625,588		5,625,588	(244,370)	5,381,218			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,890)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,328)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,949)	24		19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(225)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(42,233)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,400)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,775)		\$	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)	(183,595)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (183,595)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (244,370)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Report Period Beginning: ID# 0039347
Ending: 01/01/2012
12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Eliminate PAC dues including lobbying portion	\$ (2,797)	20	1
2	Add back 2012 IDPH license paid in 2010	1,990	20	2
3	Eliminate depreciation exp. for non-medicaid assets	(2,338)	30	3
4	Eliminate non-allowable dues	(275)	20	4
5	Eliminate 2 year IDPH license paid in 2012	(3,980)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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33				33
34				34
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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	(7,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0039347 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	535	0	0	0	0	0	0	0	0	0	535	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	535	0	0	0	0	0	0	0	0	0	535	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	73,627	(291,860)	0	0	0	0	0	0	0	0	(218,233)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(225)	3,591	(3,724)	0	0	0	0	0	0	0	0	(358)	19
20	Fees, Subscriptions & Promotions	(49,373)	1,308	0	0	0	0	0	0	0	0	0	(48,065)	20
21	Clerical & General Office Expenses	0	54,594	0	0	0	0	0	0	0	0	0	54,594	21
22	Employee Benefits & Payroll Taxes	0	12,566	0	0	0	0	0	0	0	0	0	12,566	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,949)	4,125	0	0	0	0	0	0	0	0	0	2,176	24
25	Other Admin. Staff Transportation	0	1,876	0	0	0	0	0	0	0	0	0	1,876	25
26	Insurance-Prop.Liab.Malpractice	0	1,884	0	0	0	0	0	0	0	0	0	1,884	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(51,547)	153,571	(295,584)	0	0	0	0	0	0	0	0	(193,560)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(51,547)	154,106	(295,584)	0	0	0	0	0	0	0	0	(193,025)	29

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	(2,338)	0	0	0	0	0	0	0	0	0	0	(2,338)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,890)	1	(20,530)	0	0	0	0	0	0	0	0	(27,419)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,970	0	0	0	0	0	0	0	0	0	8,970	34
35	Rent-Equipment & Vehicles	0	2,929	0	0	0	0	0	0	0	0	0	2,929	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,228)	11,900	(20,530)	0	0	0	0	0	0	0	0	(17,858)	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	(33,487)	0	0	0	0	0	0	0	0	(33,487)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(33,487)	0	0	0	0	0	0	0	0	(33,487)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(60,775)	166,006	(349,601)	0	0	0	0	0	0	0	0	(244,370)	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
John H. Rothert	60	Jerseyville Nursing and Rehabilitation Ctr., Inc.	Jerseyville, IL	Wellington Mgt. Co.	Chesterfield, MO	Management Co.
David L. Kamler	20	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	20	Spanish Lake Nursing and Rehabilitation Ctr.	Florissant, MO	C.J. Schlosser & Co.	Alton, IL	Public Accountants
				NW Rehab, L.L.C.	Alton, IL	Therapy Co.
				Three Amigos, L.L.C.	Alton, IL	Real Estate Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	See Schedule VIII	\$	Wellington Management Company	60.00%	\$ 535	\$ 535	1
2	V	17	See Schedule VIII		Wellington Management Company	60.00%	73,627	73,627	2
3	V	19	See Schedule VIII		Wellington Management Company	60.00%	3,591	3,591	3
4	V	20	See Schedule VIII		Wellington Management Company	60.00%	1,308	1,308	4
5	V	21	See Schedule VIII		Wellington Management Company	60.00%	54,594	54,594	5
6	V	22	See Schedule VIII		Wellington Management Company	60.00%	12,566	12,566	6
7	V	24	See Schedule VIII		Wellington Management Company	60.00%	4,125	4,125	7
8	V	25	See Schedule VIII		Wellington Management Company	60.00%	1,876	1,876	8
9	V	26	See Schedule VIII		Wellington Management Company	60.00%	1,884	1,884	9
10	V	32	See Schedule VIII		Wellington Management Company	60.00%	1	1	10
11	V	34	See Schedule VIII		Wellington Management Company	60.00%	8,970	8,970	11
12	V	35	See Schedule VIII		Wellington Management Company	60.00%	2,929	2,929	12
13	V								13
14	Total			\$			\$ 166,006	\$ * 166,006	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing and Medical Records	\$ 30,843	Wellington Management Company	60.00%	\$ 30,843	\$	15
16	V	17 Management Fees	208,295	Wellington Management Company	60.00%		(208,295)	16
17	V	17 Management Fees	138,863	Health Care Financial, LLC	40.00%	55,298	(83,565)	17
18	V	19 Professional Services	3,724	C.J. Schlosser & Company, LLC	40.00%		(3,724)	18
19	V	39 Therapy Services	596,208	NW Rehab, LLC	100.00%	562,721	(33,487)	19
20	V	32 Interest	10,715	John H. Rothert	60.00%		(10,715)	20
21	V	32 Interest	3,810	J. Terry Dooling	20.00%		(3,810)	21
22	V	32 Interest	6,005	David L. Kamler	20.00%		(6,005)	22
23	V	21 Clerical	14,623	Wellington Management Company	60.00%	14,623		23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,013,086			\$ 663,485	\$ * (349,601)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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								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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	286,373	8.18	20.45	Salary	\$ 73,627	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,627		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr # 0039347 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Accumulated Costs	23,045,618	6	\$ 2,614	\$	4,713,267	\$ 535	1
2	17	Administrative	Accumulated Costs	23,045,618	6	360,000	360,000	4,713,267	73,627	2
3	19	Professional Services	Accumulated Costs	23,045,618	6	17,560		4,713,267	3,591	3
4	20	Dues, Fees, Subs, & Promos	Accumulated Costs	23,045,618	6	6,397		4,713,267	1,308	4
5	21	Clerical & General Office Exp.	Accumulated Costs	23,045,618	6	266,939	234,867	4,713,267	54,594	5
6	22	Employee Benefits & PR Taxes	Accumulated Costs	23,045,618	6	61,440		4,713,267	12,566	6
7	24	Travel & Seminar	Accumulated Costs	23,045,618	6	20,170		4,713,267	4,125	7
8	25	Other Admin Staff Transport	Accumulated Costs	23,045,618	6	9,173		4,713,267	1,876	8
9	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	23,045,618	6	9,210		4,713,267	1,884	9
10	32	Interest Expense	Accumulated Costs	23,045,618	6	5		4,713,267	1	10
11	34	Rent - Facility & Ground	Accumulated Costs	23,045,618	6	43,859		4,713,267	8,970	11
12	35	Rent - Equipment & Vehicles	Accumulated Costs	23,045,618	6	14,319		4,713,267	2,929	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					\$ 811,686	\$ 594,867		\$ 166,006	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Berkadia		X	Refinance Mortgage	\$13,209.94	11/30/06	\$ 2,415,500	\$ 2,255,917	11/30/41	5.6500	\$ 127,009	1	
2												2	
3									Loan Cost Amortization		1,392	3	
4									Interest Income		(6,890)	4	
5									Home Office Interest		1	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$13,209.94		\$ 2,415,500	\$ 2,255,917			\$ 121,512	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,415,500	\$ 2,255,917			\$ 121,512	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 11,362 Line # 36

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	52,000	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.)			\$	49,906	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,094)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	52,000	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.			\$	49,906	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007 44,524 8	FOR BHF USE ONLY		
		2008 47,841 9	13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
		2009 50,581 10	14	PLUS APPEAL COST FROM LINE 5 \$	14
		2010 49,547 11	15	LESS REFUND FROM LINE 6 \$	15
		2011 49,906 12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
Line 2 : 2011 Taxes Paid					
Line 4 : Accrual is based on 2011 taxes paid plus 3.5% rounded to nearest \$1,000					

- 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.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nrsg & Rehab Ctr COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>16-13-379-001</u>	<u>NE PT SE SW Land Corp Limit</u>	\$ <u>49,905.98</u>	\$ <u>49,905.98</u>
2.	<u></u>	<u>Taylor Springs 8-4-716 3/4 S13</u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u>T08 R4</u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>49,905.98</u></u>	\$ <u><u>49,905.98</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

A. Square Feet:

27,192

B. General Construction Type:

Exterior

Brick

Frame

Steel & Brick

Number of Stories

1

C. Does the Operating Entity?

X

(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?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			1994		\$ 962,086	\$ 38,483	25	\$ 38,483	\$	\$ 721,565
5										
6										
7										
8										
	Improvement Type**									
9	Shed		1994		3,247		10			3,247
10	Air Conditioner		1994		76,140		10			76,140
11	Cabinets		1994		6,809	340	20	340		6,214
12	Doors		1994		2,337	117	20	117		2,142
13	Electrical		1994		4,601	230	20	230		4,175
14	Exterior Remodeling		1994		4,468		15			4,468
15	Interior Remodeling		1994		57,810		15			57,810
16	Nurse Call System		1994		1,960		15			1,960
17	Plumbing		1994		6,619	331	20	331		6,031
18	Windows/Gutters		1994		60,254		15			60,254
19	Siding		1994		15,818		15			15,818
20	Metal Doors & Frames		1996		953	48	20	48		786
21	Metal Carport		1997				15			
22	Dining Room Chair Rail		1997		2,230	149	15	149		2,230
23	Fire Doors		1997		593	30	20	30		445
24	Interior Painting		1997		514		5			514
25	Sidewalk Replacement		1997		650	40	15	40		650
26	Beauty Shop Remodeling		1998		4,287	214	20	214		3,055
27	Shower Room Remodeling		1998		1,199	60	20	60		859
28	Shelving		1998		566	28	20	28		408
29	Water Heater		1998		6,040	403	15	403		5,738
30	Shelving		1998		208		10			208
31	Wall Mounted Laundry Tub		1998		181	9	20	9		135
32	Air Conditioning Unit		2000		557		10			557
33	Fire Doors		2001		1,535	102	15	102		1,185
34	Cove Base		2001				10			
35	Air Conditioning Unit		2001		1,696		10			1,696
36	Cove Base		2002				10			

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

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

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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0039347

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioning Unit	2002	\$ 1,446	\$ (112)	10	\$ (112)	\$	\$ 1,446	37
38	Flooring & Cove Base	2002			10				38
39	Wall Guard	2002	1,927	128	15	128		1,392	39
40	Fire Doors	2002	1,042	69	15	69		729	40
41	AC/Heat Pumps	2002	1,580	92	10	92		1,580	41
42	Air Conditioning Unit	2003	3,110	311	10	311		2,917	42
43	11 Fire Doors	2003	5,950	397	15	397		3,669	43
44	Closet Doors - Resident Rooms	2004	3,628	242	15	242		2,058	44
45	Wiring Outside Lights	2004	1,145	57	20	57		510	45
46	Tile	2004	878	88	10	88		783	46
47	Commercial Water Heater	2004	7,664	766	10	766		6,514	47
48	Floor Tile	2004	1,186	119	10	119		959	48
49	66 Gallon Hot Water Heater	2004	931	93	10	93		752	49
50	Patio and Sidewalks	2004	14,316	954	15	954		7,954	50
51	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		861	51
52	Range Hood	2005	832	42	20	42		333	52
53	Closet Doors - Resident Rooms	2005	3,689	369	10	369		2,868	53
54	Outside Light Fixtures	2005	2,025	203	10	203		1,562	54
55	Air Conditioning Unit	2005	7,610	761	10	761		5,678	55
56	Electrical Work	2005	5,528	276	20	276		2,073	56
57	Tile and Cove Base	2005	2,064	206	10	206		1,531	57
58	Heating/Cooling Unit	2005	558		5			558	58
59	Wallpaper	2005	811		5			811	59
60	Therapy Room Cabinets	2005	1,200	80	15	80		560	60
61	New Roof - 200 & 500 Wings	2005	74,745	4,983	15	4,983		36,127	61
62	Wall Guard	2006	570	38	15	38		260	62
63	6 Oak Doors	2006	3,469	231	15	231		1,522	63
64	Smoke Detectors	2006	683	68	10	68		455	64
65	Exhaust Fans for Kitchen	2006	1,034	103	10	103		646	65
66	New Roof - 300 Wing	2007	30,200	3,020	10	3,020		17,617	66
67	Shower & Wall Remodel	2007	5,510	276	20	276		1,630	67
68	Water Heaters	2006	1,695	170	10	170		1,111	68
69	Air Conditioning Unit	2006	3,414	103	5-10	103		3,061	69
70	TOTAL (lines 4 thru 69)		\$ 1,415,318	\$ 54,818		\$ 54,818	\$	\$ 1,088,817	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nrsg & Rehab Ctr

0039347

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,415,318	\$ 54,818		\$ 54,818	\$	\$ 1,088,817	1
2	Storage Shed	2006	1,583	158	10	158		1,036	2
3	Fire Doors	2006	4,939	329	15	329		2,030	3
4	Patio & Sidewalks	2006	9,566	638	15	638		4,149	4
5	Exhaust Fan Replacement	2007	3,862	386	10	386		1,996	5
6	Interior Remodeling - Shower Room	2007	20,896	1,045	20	1,045		5,516	6
7	Water Heaters	2007	10,972	1,097	10	1,097		6,312	7
8	Doors - Metal	2007	4,450	223	20	223		1,255	8
9	Air Conditioning Units	2007	3,512	433	5	433		3,512	9
10	Flooring	2007	10,399	1,040	10	1,040		5,454	10
11	Landscaping - Sign Area	2007	2,575	258	10	258		1,438	11
12	Repaved Driveway	2007	4,750	594	8	594		3,216	12
13	Flooring	2008	132,076	13,208	10	13,208		60,307	13
14	Wallpapering	2008	45,923	9,185	5	9,185		42,389	14
15	Electrical Work	2008	11,765	588	20	588		2,690	15
16	5 A/C Units & Installation	2008	8,021	802	10	802		3,677	16
17	Facility Signage	2008	8,602	1,720	5	1,720		7,665	17
18	8 Oak Doors	2008	4,659	311	15	311		1,346	18
19	In Wall Fountain - Labor & Materials	2008	5,321	760	7	760		3,420	19
20	Handrails & Hardware	2008	8,950	597	15	597		2,834	20
21	Cabinets, Countertops, & Sinks	2008	28,200	1,880	15	1,880		8,930	21
22	5 Shaped Cornices	2008	3,034	303	10	303		1,315	22
23	Cabinet Installation	2008	3,320	221	15	221		922	23
24	3 A/C Units	2009	1,839	368	5	368		1,287	24
25	Sinks/Faucets - Resident Rooms	2009	2,985	149	20	149		482	25
26	Generator	2009	50,432	2,522	20	2,522		9,666	26
27	Rood Replacement - 100 & 400 Halls	2009	36,200	3,620	10	3,620		13,273	27
28	10 Upholstered Cornices	2009	5,255	526	10	526		2,014	28
29	Wi-Fi Access Installation	2009	1,892	95	20	95		331	29
30	130 Gallon Water Heater	2009		1,059	10	1,059			30
31	Ceiling Tiles - Therapy Room	2009	676	68	10	68		225	31
32	Plexiglass for Maint. Shed	2009	758	76	10	76		240	32
33	Closet Doors	2009	548	55	10	55		174	33
34	TOTAL (lines 1 thru 33)		\$ 1,853,278	\$ 99,132		\$ 99,132	\$	\$ 1,287,918	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,853,278	\$ 99,132		\$ 99,132	\$	\$ 1,287,918	1
2	New Entry Door	2010	3,000	300	10	300		775	2
3	4 A/C/Heat Units	2010	2,618	523	5	523		1,219	3
4	New 400 Amp Breaker	2010	1,787	119	15	119		288	4
5	Flooring	2010	5,340	534	10	534		1,106	5
6	Insulate Duct Work	2010	14,800	987	15	987		1,973	6
7	Kitchen Flooring	2011	4,520	452	10	452		866	7
8	Breaker Panel & Installation	2011	10,994	550	20	550		1,008	8
9	Sprinkler System	2011	117,500	4,700	25	4,700		7,833	9
10	6 A/C/Heat Units	2011	4,502	900	5	900		1,372	10
11	Motion Sensor/Detectors	2011	1,094	219	5	219		328	11
12	Water Heater	2011	1,145	114	10	114		143	12
13	Sidewalks	2011	3,850	257	15	257		371	13
14	Vinyl Fence and Gate	2011	5,325	532	10	532		755	14
15	Asphalt/Seal/Stripe/Patch & Repair Parking Lot	2011	28,870	3,609	8	3,609		4,530	15
16	Drainage Downspouts Installation	2011	2,880	288	10	288		336	16
17	Windows - Remove and Replace	2012	9,480	316	10	316		316	17
18	Flooring - Shower Room	2012	4,602	383	10	383		383	18
19	Flooring - Lunch Room	2012	1,783	163	10	163		163	19
20	2 Electric Heater/ A/C Units	2012	1,605	321	5	321		321	20
21	Security Locks	2012	7,870	271	10	271		271	21
22	Light Fixtures - Weather Proof	2012	4,471	149	10	149		149	22
23	100 Gal. Hot Water Heater	2012	8,042	134	10	134		134	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,099,356	\$ 114,953		\$ 114,953	\$	\$ 1,312,558	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 507,286	\$ 52,766	\$ 52,766	\$	5-10	\$ 199,522	71
72	Current Year Purchases	90,716	3,220	3,220		5-20	3,220	72
73	Fully Depreciated Assets	314,256	641	641		5-20	314,257	73
74								74
75	TOTALS	\$ 912,258	\$ 56,627	\$ 56,627	\$		\$ 516,999	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 Use	2004 Ford Wheelchair Van	2004	\$ 35,799	\$	\$	\$	4	\$ 35,799	76
77	Facility Use	2002 Dodge 3500 Ram Wheelchai	2011	5,266	1,317	1,317		4	1,536	77
78										78
79										79
80	TOTALS			\$ 41,065	\$ 1,317	\$ 1,317	\$		\$ 37,335	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,080,352 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 172,897 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 172,897 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)	\$ 1,866,892 85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 9,128
- Description: Postage Machine \$799; Copier \$5,400; Home Office Vehicle Lease \$2929
- (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	Section Not Applicable		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER CNA

80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☒

IN OTHER FACILITY

☐

HOURS PER CNA

40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		956		956
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		5,760		5,760
6	Transportation				
7	Contractual Payments		360		360
8	CNA Competency Tests		755		755
9	TOTALS	\$	\$ 7,831	\$	\$ 7,831
10	SUM OF line 9, col. 1 and 2 (e)	\$	7,831		

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	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							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				110,816		110,816	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached Schedule				14,997	582,064	13,166	14,997	595,230	12
13	Other (specify): 									13
14	TOTAL			\$	14,997	\$ 582,064	\$ 123,982	14,997	\$ 706,046	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 74,669	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,149,604		3
4	Supply Inventory (priced at)	18,334		4
5	Short-Term Investments			5
6	Prepaid Insurance	39,219		6
7	Other Prepaid Expenses	265		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	21,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,303,091	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	105,347		13
14	Buildings, at Historical Cost	2,063,515		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	935,011		16
17	Accumulated Depreciation (book methods)	(1,878,424)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	113,063		21
22	Other Long-Term Assets (specify) Loan Costs	40,238		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,398,950	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,702,041	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 827,106	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,346		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,651		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	9,479		36
37	Accrued Provider Tax	93,212		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,192,794	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,793		39
40	Mortgage Payable	2,295,831		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,488,624	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,681,418	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (979,377)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,702,041	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,181,428)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,181,428)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	402,051	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	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 202,051	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)	\$ (979,377)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 4,879,933	1	
2 Discounts and Allowances for all Levels	147,293	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,027,226	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	971,142	6	
7 Oxygen	1,152	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 972,294	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements	9,892	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	6,718	19	
20 Radiology and X-Ray	3,951	20	
21 Other Medical Services		21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,561	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	6,890	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,890	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous	668	28	
28a		28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 668	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,027,639	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	994,909	31	
32 Health Care	1,997,392	32	
33 General Administration	1,130,623	33	
B. Capital Expense			
34 Ownership	400,104	34	
C. Ancillary Expense			
35 Special Cost Centers	1,102,560	35	
36 Provider Participation Fee		36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,625,588	40	
41 Income before Income Taxes (line 30 minus line 40)**	402,051	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 402,051	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 2,280,436	44	
45 Private Pay - Net Inpatient Revenue	1,700,916	45	
46 Medicare - Net Inpatient Revenue	1,006,112	46	
47 Other-(specify) <u>Hospice</u>	39,762	47	
48 Other-(specify)		48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,027,226	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,195	2,196	\$ 57,096	\$ 26.00	1
2	Assistant Director of Nursing	1,877	2,172	53,602	24.68	2
3	Registered Nurses	4,874	5,197	108,380	20.85	3
4	Licensed Practical Nurses	23,302	25,063	423,962	16.92	4
5	CNAs & Orderlies	95,782	102,067	1,011,458	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,178	5,480	51,507	9.40	10
11	Social Service Workers	1,943	2,133	41,832	19.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,999	25,550	255,956	10.02	15
16	Dishwashers					16
17	Maintenance Workers	3,089	3,420	55,365	16.19	17
18	Housekeepers	12,388	13,242	128,950	9.74	18
19	Laundry	9,399	9,824	85,006	8.65	19
20	Administrator	1,807	2,076	87,639	42.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,361	3,937	71,744	18.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,662	1,969	20,205	10.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,856	204,326	\$ 2,452,702 *	\$ 12.00	34

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	112	\$ 6,568	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	17	1,229	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,464	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	9	410	11,3	44
45	Social Service Consultant	8	410	12,3	45
46	Other(specify) Compliance Consultant	123	6,248	10,3	46
47	Quality Assurance Nurse	N/A	30,843	10,3	47
48	Clerical	N/A	14,623	21,3	48
49	TOTAL (lines 35 - 48)	269	\$ 74,395		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

0039347

Report Period Beginning:

01/01/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Montgomery Nrsg & Rehab Ctr

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		
Carla Vonder Haar		Administrator		\$ 87,639	Workers' Compensation Insurance		\$ 44,489	IDPH License Fee		\$ 1,990		
					Unemployment Compensation Insurance		42,597	Advertising: Employee Recruitment		7,636		
					FICA Taxes		184,138	Health Care Worker Background Check				
					Employee Health Insurance		50,891	(Indicate # of checks performed 14)		219		
					Employee Meals			Patient Background Checks		66 1,062		
					Illinois Municipal Retirement Fund (IMRF)*			Dues, Subscriptions, & Manuals		4,087		
					Staff Relations		20,138	Licenses & Fees		1,072		
					Employee Dental/Vision Insurance		3,222	Bank Service Charges		4,225		
					Home Office Employee Benefits		12,566	IHCA Dues		3,803		
					Employee Deductible Reimb. Expense		1,300	Home Office Dues, Fees, Subscriptions		1,308		
					Employee Life/Disability Insurance		1,453	Less: Public Relations Expense		()		
								Non-allowable advertising		()		
								Yellow page advertising		()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 87,639	TOTAL (agree to Schedule V, line 22, col.8)				\$ 360,794	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,402
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount		
Wellington Management Co. - Management Fees			\$ 208,295	Section N/A			\$	Out-of-State Travel		\$		
Health Care Financial, LLC - Management Fees			138,863									
								In-State Travel		4,275		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 347,158					Seminar Expense		5,556	
C. Professional Services									Home Office Travel & Seminar		4,125	
Vendor/Payee		Type	Amount									
C.J. Schlosser & Co., LLC		Accounting Services	\$ 3,724									
May, Cocagne, & King		Audit Fees	9,000									
Sandberg Phoenix & von Gontard P.		Legal Services	664									
Burnside, Johnston, Sheafor & Kelly		Collection Fees (eliminated)	225									
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 13,613	TOTAL				\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		()

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

Illinois Healthcare Association
- (3)

Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 15,131

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.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 359,903

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

None
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None

Has any meal income been offset against related costs?

No

Indicate the amount.

\$ N/A
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

48.35%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

None

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

May, Cocagne & King
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

MONTGOMERY NURSING & REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2012

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
ACTIVITIES	11	123
SOCIAL SERVICES	12	(123)
To reclass activites consultant fee to the correct line		
ADMINISTRATIVE	17	(3,497)
PROFESSIONAL SERVICES	19	3,497
To reclass Acctg Fees to the proper line		
NURSE AIDE TRAINING	13	5,760
NURSING & MEDICAL RECORDS	10	(5,760)
To reclass CNA trainer wages		

Montgomery Nursing and Rehabilitation Center
Attachment to Sch. XVII
12/31/2012

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	\$ 402,051
CONVERSION TO CASH BASIS ADJUSTMENTS	<u>16,244</u>
SUBTOTAL	418,295
DEPRECIATION ADJUSTMENT	(254,536)
GAIN ON DISPOSAL OF FIXED ASSETS ADJUSTMENT	7,007
MISC. NON-DEDUCTIBLE EXPENSE	26,946
TAX NET INCOME (LOSS), PER FEDERAL RETURN	\$ <u><u>197,712</u></u>

MONTGOMERY NURSING & REHABILITATION CENTER
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/2012

Miscellaneous Income	668
	<u>668</u>

Montgomery Nursing & Rehabilitation Center
 Attachment to Schedule XIV
 12/31/2012

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5 +6)
Line #	Service	Schuler V Line & Column Referenc e	Units of Service	Cost	Units of Service	Cost	Cost		
12	Other:								
	Licensed Occupational Therapist	39,8			6,024	226,087	1,537	6,024	227,624
	Licensed Speech Therapist	39,8			2,441	98,394		2,441	98,394
	Licensed Physical Therapist	39,8			6,532	238,240	5,476	6,532	243,716
	X-Ray	39,3				5,854		-	5,854
	Laboratory	39,3				13,489		-	13,489
	Specialty Mattresses/Overlays	39,3					6,153	-	6,153
Total to Schedule XIV, Line 12			-	-	14,997	582,064	13,166	14,997	595,230

MONTGOMERY NURSING & REHAB CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2012

<u>Seminar Participant</u>	<u>Job Title</u>	<u>Dates</u>	<u>City</u>	<u>Title of Seminar</u>	<u>Sponsor</u>
Cathy Brummett	Activities Director	3/8/2012	Online-6 month course	Activity Director Correspondence Course	Outcome Services of Illinois
Rebecca Durbin	C.N.A. Instructor	12/5/11-12/9/11	Springfield	C.N.A. Instructor Course	Capital City Training Center

Total Seminar Lodging/Travel/Meals
CPR Training
Online CPE Service for Nurses
Other Travel Expenses <\$250
Home Office Travel & Seminar

Total Travel & Seminar, Line 24

<u>Cost</u>	<u>Seminar Lodging Travel/Meals</u>
400	
480	

880	0
-----	---

0
1,526
3,150
4,275
4,125
<u>13,956</u>