

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0037515</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Montgomery Place</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2015</u> to <u>06/30/2016</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>5550 South Shore Dr</u> <u>Chicago</u> <u>60637</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 753-4100</u> Fax # <u>(773) 752-0056</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>Fred A. Saviano</u></td></tr><tr><td>(Title) <u>Chie Financial Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Scott E. Martin</u> and Title) <u>CPA, Director</u></td></tr><tr><td>(Firm Name <u>Crowe Horwath LLP</u> & Address) <u>330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624-000</u></td></tr><tr><td>(Telephone) <u>(574) 232-3992</u> Fax # <u>(574) 236-8692</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Fred A. Saviano</u>	(Title) <u>Chie Financial Officer</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name <u>Scott E. Martin</u> and Title) <u>CPA, Director</u>	(Firm Name <u>Crowe Horwath LLP</u> & Address) <u>330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624-000</u>	(Telephone) <u>(574) 232-3992</u> Fax # <u>(574) 236-8692</u>												
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	(Telephone) <u>(574) 232-3992</u> Fax # <u>(574) 236-8692</u>																								
Date of Initial License for Current Owners: <u>01/24/1992</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 <u>501[C][3]</u></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 <u>501[C][3]</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Fred A. Saviano, CFO</u> Telephone Number: <u>(773) 753-4100</u>																									
Email Address: _____																									

Facility Name & ID Number Montgomery Place

0037515 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	<u>40</u>	Skilled (SNF)	<u>40</u>	<u>14,640</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>40</u>	TOTALS	<u>40</u>	<u>14,640</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>600</u>	<u>6,978</u>	<u>4,298</u>	<u>11,876</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>600</u>	<u>6,978</u>	<u>4,298</u>	<u>11,876</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.12%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 01/28/1992

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 3,647

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2016 Fiscal Year: 06/30/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	894,438	160,727	(46,093)	1,009,072		1,009,072	(699,926)	309,146			1
2	Food Purchase		814,970		814,970		814,970	(577,403)	237,567			2
3	Housekeeping	292,665	47,531	3,563	343,759		343,759	(334,413)	9,346			3
4	Laundry	61,620	11,080	2,796	75,496		75,496	(16,965)	58,531			4
5	Heat and Other Utilities			424,560	424,560	40,162	464,722	(451,467)	13,255			5
6	Maintenance	296,004	54,004	307,517	657,525		657,525	(426,361)	231,164			6
7	Other (specify):*											7
8	TOTAL General Services	1,544,727	1,088,312	692,343	3,325,382	40,162	3,365,544	(2,506,535)	859,009			8
	B. Health Care and Programs											
9	Medical Director			32,614	32,614		32,614		32,614			9
10	Nursing and Medical Records	1,376,058	41,751	89,301	1,507,110		1,507,110		1,507,110			10
10a	Therapy		206	484,611	484,817		484,817		484,817			10a
11	Activities	92,801	875	6,716	100,392		100,392		100,392			11
12	Social Services	50,440	989		51,429		51,429		51,429			12
13	CNA Training											13
14	Program Transportation	41,174	526		41,700		41,700	(32,364)	9,336			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,560,473	44,347	613,242	2,218,062		2,218,062	(32,364)	2,185,698			16
	C. General Administration											
17	Administrative					113,278	113,278	(69,943)	43,335			17
18	Directors Fees											18
19	Professional Services			563,810	563,810		563,810	(420,696)	143,114			19
20	Dues, Fees, Subscriptions & Promotions			65,249	65,249		65,249	(41,216)	24,033			20
21	Clerical & General Office Expenses	957,092	8,882	295,373	1,261,347	(113,278)	1,148,069	(740,871)	407,198			21
22	Employee Benefits & Payroll Taxes			1,009,829	1,009,829		1,009,829	(526,859)	482,970			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,586	180,586		180,586	(175,435)	5,151			26
27	Other (specify):*			28,770	28,770		28,770	(28,770)				27
28	TOTAL General Administration	957,092	8,882	2,143,617	3,109,591		3,109,591	(2,003,790)	1,105,801			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,062,292	1,141,541	3,449,202	8,653,035	40,162	8,693,197	(4,542,689)	4,150,508			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.

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			2,479,504	2,479,504		2,479,504	(2,134,841)	344,663			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,882,577	1,882,577		1,882,577	(1,828,881)	53,696			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			92,566	92,566	(40,162)	52,404	(32,357)	20,047			35
36	Other (specify):*			24,354	24,354		24,354	(24,354)				36
37	TOTAL Ownership			4,479,001	4,479,001	(40,162)	4,438,839	(4,020,433)	418,406			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,506	8,910	133,416		133,416		133,416			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,902	70,902		70,902		70,902			42
43	Other (specify):*	521,526	35,637	920,304	1,477,467		1,477,467	(1,477,467)				43
44	TOTAL Special Cost Centers	521,526	160,143	1,000,116	1,681,785		1,681,785	(1,477,467)	204,318			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,583,818	1,301,684	8,928,319	14,813,821		14,813,821	(10,040,589)	4,773,232			45

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

SCHEDULE V, COLUMN 5 - RECLASSIFICATIONS			To Line	From Line
Administrator wages	\$	113,278	17	21
Senior TV	\$	40,162	05	35

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(39,537)	2		4
5	Telephone, TV & Radio in Resident Rooms	(43,101)	21		5
6	Rented Facility Space	(2,398)	3		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,828,881)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(36,000)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,610)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,160)	27		24
25	Fund Raising, Advertising and Promotional	(500,502)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A Detail	(7,561,400)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,040,589)		\$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (10,040,589)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL Dietary Costs	\$ (699,926)	1	1
2	AL/IL Food Purchases	(537,866)	2	2
3	AL/IL Housekeeping	(318,307)	3	3
4	Rev Offset - Housekeeping	(13,708)	3	4
5	Rev Offset - Laundry	(16,965)	4	5
6	AL/IL Heat & Other Utilities	(451,467)	5	6
7	Rev Offset - Miscellaneous Services	(53,260)	6	7
8	AL/IL Maintenance	(373,101)	6	8
9	AL/IL Transportation	(15,068)	14	9
10	Rev Offset - Transportation	(17,296)	14	10
11	AL/IL Administrator	(69,943)	17	11
12	AL/IL Professional Services	(230,989)	19	12
13	Unallowable Legal	(189,707)	19	13
14	AL/IL Dues, Fees, Subscriptions	(38,790)	20	14
15	Lobbying Expenses	(2,426)	20	15
16	AL/IL Office & Clerical	(657,224)	21	16
17	Music Fund Expenses	(757)	21	17
18	Library Fund Expenses	(1,445)	21	18
19	Rev Offset - Other Miscellaneous	(2,344)	21	19
20	Marketing Employee Benefits	(34,715)	22	20
21	AL/IL Specific Employee Benefits	(53,352)	22	21
22	AL/IL Allocated Employee Benefits	(438,792)	22	22
23	AL/IL Insurance	(175,435)	26	23
24	AL/IL Equip Depreciation Expense	(2,134,841)	30	24
25	AL/IL Equip Rental	(32,357)	35	25
26	Unallowable Interest Expense (Investment Fees)	(24,354)	36	26
27	AL/IL Specific Expenses	(976,965)	43	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	(7,561,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	(699,926)	0	0	0	0	0	0	0	0	0	0	(699,926)	1
2	Food Purchase	(577,403)	0	0	0	0	0	0	0	0	0	0	(577,403)	2
3	Housekeeping	(334,413)	0	0	0	0	0	0	0	0	0	0	(334,413)	3
4	Laundry	(16,965)	0	0	0	0	0	0	0	0	0	0	(16,965)	4
5	Heat and Other Utilities	(451,467)	0	0	0	0	0	0	0	0	0	0	(451,467)	5
6	Maintenance	(426,361)	0	0	0	0	0	0	0	0	0	0	(426,361)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,506,535)	0	0	0	0	0	0	0	0	0	0	(2,506,535)	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	(32,364)	0	0	0	0	0	0	0	0	0	0	(32,364)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(32,364)	0	0	0	0	0	0	0	0	0	0	(32,364)	16
	C. General Administration													
17	Administrative	(69,943)	0	0	0	0	0	0	0	0	0	0	(69,943)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(420,696)	0	0	0	0	0	0	0	0	0	0	(420,696)	19
20	Fees, Subscriptions & Promotions	(41,216)	0	0	0	0	0	0	0	0	0	0	(41,216)	20
21	Clerical & General Office Expenses	(740,871)	0	0	0	0	0	0	0	0	0	0	(740,871)	21
22	Employee Benefits & Payroll Taxes	(526,859)	0	0	0	0	0	0	0	0	0	0	(526,859)	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	(175,435)	0	0	0	0	0	0	0	0	0	0	(175,435)	26
27	Other (specify):*	(28,770)	0	0	0	0	0	0	0	0	0	0	(28,770)	27
28	TOTAL General Administration	(2,003,790)	0	0	0	0	0	0	0	0	0	0	(2,003,790)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(4,542,689)	0	0	0	0	0	0	0	0	0	0	(4,542,689)	29

Summary B

06/30/2016

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

☐ YES

☒ NO

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

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

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

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

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

Facility Name & ID Number Montgomery Place# 0037515

Report Period Beginning:

07/01/2015Ending: 6/30/2016

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

Montgomery Place Assisted & Independent Living

Street Address

5550 Shouth Shore Drive

City / State / Zip Code

Chicago, IL 60637

Phone Number

(773) 753-4100

Fax Number

(773) 752-0056

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Meals	114,079	2	\$ 1,009,072	\$ 894,438	34,950	\$ 309,146	1
2	2	Food	Meals	114,079	2	775,433		34,950	237,567	2
3	3	Housekeeping	Square Feet	203,488	2	327,653	292,665	5,804	9,346	3
4	4	Laundry	Actual	75,496	1	58,531	61,620	58,531	58,531	4
5	5	Utilities	Square Feet	203,488	2	464,722		5,804	13,255	5
6	6	Maintenance	Revenue	11,812,598	2	604,265	296,004	4,518,948	231,164	6
7	9	Medical Director	Actual	32,614	1	32,614		32,614	32,614	7
8	10	Nursing/Medical Records	Actual	1,507,110	1	1,507,110	1,376,058	1,507,110	1,507,110	8
9	10A	Therapy	Actual	484,817	1	484,817		484,817	484,817	9
10	11	Activities	Actual	100,392	1	100,392	92,801	100,392	100,392	10
11	12	Social Services	Actual	51,429	1	51,429	50,440	51,429	51,429	11
12	14	Program Transportation	Revenue	11,812,598	2	24,404	41,174	4,518,948	9,336	12
13	17	Administrative	Revenue	11,812,598	2	113,278	113,278	4,518,948	43,335	13
14	19	Professional Fees	Revenue	11,812,598	2	374,103		4,518,948	143,114	14
15	20	Dues and Subscriptions	Revenue	11,812,598	2	62,823		4,518,948	24,033	15
16	21	Clerical & General Office	Revenue	11,812,598	2	1,064,422	843,814	4,518,948	407,198	16
17	22	Employee Benefits	Salary	4,583,818	2	921,762		2,401,755	482,970	17
18	26	Insurance	Square Feet	203,488	2	180,586		5,804	5,151	18
19	30	Depreciation	Actual	2,479,504	2	11,812,598		344,663	344,663	19
20	32	Interest	Square Feet	203,488	2	1,882,577		5,804	53,696	20
21	35	Equipment Rental	Revenue	11,812,598	2	52,404		4,518,948	20,047	21
22	39	Ancillary	Actual	133,416	1	133,416		133,416	133,416	22
23	42	Provider Participation Fee	Actual	70,902	1	70,902		70,902	70,902	23
24										24
25	TOTALS					\$ 22,109,313	\$ 4,062,292		\$ 4,773,232	25

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	Illinois Finance Authority		X	Facility (revenue bonds)	N/A	11/20/06	\$ 40,850,000	\$ 30,870,000	5/15/2038	0.0549	\$ 1,882,577	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 40,850,000	\$ 30,870,000			\$ 1,882,577	9	
	B. Non-Facility Related*												
10	Remove AL/IL portion of interest expense										(1,828,881)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,828,881)	14	
15	TOTALS (line 9+line14)						\$ 40,850,000	\$ 30,870,000			\$ 53,696	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		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:

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.

FACILITY NAME	<u>Montgomery Place</u>	COUNTY	<u>Cook</u>
---------------	-------------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

Montgomery Place Retirement Community Assisted Living, 14,833 Square Feet, 22 Units

Montgomery Place Retirement Community Independent Living, 182,851 Square Feet, 160 Units

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

1. Total Amount Incurred:	2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	40		1992	1992	\$ 5,735,741	\$	40	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1999		37,217		20			9
10	Various		2000		143,621		20			10
11	Various		2001		117,397		20			11
12	Various		2002		68,258		20			12
13	Various		2003		95,898		20			13
14	Various		2004		76,985		20			14
15	Various		2005		7,058		20			15
16	Various		2006		14,779		20			16
17	Various		2007		12,137		20			17
18	Elevator		2008		3,481		20			18
19	Building canopy & façade		2009		5,788		20			19
20	Carpeting		2010		910		20			20
21	Various		2012		1,249		20			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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Place

0037515

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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	Elevator control repair	2013	106		20			38
39	Carpeting common areas	2014	491		5			39
40	Philip Lifeline for residents	2014	1,728		1			40
41	Automatic entrance doors	2015	7,621		5			41
42	Carpet 8 patient rooms	2015	14,292		5			42
43	HVAC & ventilation in kitchen	2015	12,402		10			43
44	Replace motor and montgomery frieght elevator - Otis elevator	2016	2,188		10			44
45								45
46								46
47								47
48	Total nursing facility building depreciation expense and accumulated depreciation		307,330		307,330		4,778,639	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)		\$ 6,359,347	\$ 307,330		\$ 307,330	\$ 4,778,639	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,025,681	\$ 33,905	\$ 33,905	\$	10	\$ 225,776	71
72	Current Year Purchases	34,279	3,428	3,428		10	3,428	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,059,960	\$ 37,333	\$ 37,333	\$		\$ 229,204	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	Auto	2007	\$ 4,110	\$	\$	\$	5	\$ 4,110	76
77										77
78										78
79										79
80	TOTALS			\$ 4,110	\$	\$	\$		\$ 4,110	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,314,842	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 344,663	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 344,663	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)	\$ 5,011,953	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted & Independent Living	\$ 47,217,072	\$ 2,134,841	\$ 27,486,242	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 47,217,072	\$ 2,134,841	\$ 27,486,242	91

G. Construction-in-Progress

	Description	Cost	
92	AL/IL Renovations	\$ 217,013	92
93			93
94			94
95		\$ 217,013	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .
9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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: \$ 52,404 Description: Copier \$7,926; Vehicle \$4,894; Various Administrative Equipment \$39,584
(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	N/A		\$	\$	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		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	10A.3	hrs	\$	41	\$ 3,890	\$	41	\$ 3,890	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		57	2,793		57	2,793	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		7,049	477,928	206	7,049	478,134	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$	7,148	\$ 484,611	\$ 206	7,148	\$ 484,817	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (20,061)	\$	1
2	Cash-Patient Deposits	1,268,300		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (68,713))	821,472		3
4	Supply Inventory (priced at)	20,638		4
5	Short-Term Investments			5
6	Prepaid Insurance	54,973		6
7	Other Prepaid Expenses	49,613		7
8	Accounts Receivable (owners or related parties)	21,798		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,216,733	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,087,515		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	47,333,619		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,944,683		16
17	Accumulated Depreciation (book methods)	(32,498,195)		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 (spe Construction in Progr 217,013			22
23	Other(specify): See Supplemental Schedule 7,982,083			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 40,320,330	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 42,537,063	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 326,621	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	778,256		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	594,875		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,699,752	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	30,870,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Original Bond Issue, net	385,005		43
44	See Supplemental Schedule	28,197,297		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 59,452,302	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 61,152,054	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (18,614,991)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 42,537,063	\$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Long-Term Assets		Line 44 - Other Long-term Liabilities	
Description	Amount	Description	Amount
Assets limited as to use - Bond funds	\$ 7,171,369	Due to affiliate - Church Home	\$ 2,720,706
Bond financing costs, net	759,683	Refundable entrance fees, net of amortization	24,938,038
Assets limited as to use - donor restricted	51,031	Nonrefundable entrance fees, net of amortization	538,553
	<u>\$ 7,982,083</u>		<u>\$28,197,297</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (15,962,765)	1
2	Restatements (describe):		2
3	Adjust to final audited amount for FYE 6/30/2015	(92,653)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (16,055,418)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,619,730)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Temporarily Restricted Assets	60,157	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,559,573)	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)	\$ (18,614,991)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Montgomery Place**# **0037515**Report Period Beginning: **07/01/2015**Ending: **06/30/2016**

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	\$ 4,518,948	1
2	Discounts and Allowances for all Levels	(1,619,864)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,899,084	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,146,356	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,146,356	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,321	13
14	Non-Patient Meals	39,537	14
15	Telephone, Television and Radio	43,101	15
16	Rental of Facility Space	25,736	16
17	Sale of Drugs	10,097	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	97,257	19
20	Radiology and X-Ray	6,595	20
21	Other Medical Services	208,748	21
22	Laundry	16,965	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 462,357	23
	D. Non-Operating Revenue		
24	Contributions	7,466	24
25	Interest and Other Investment Income***	(46,425)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (38,959)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See PG19 Supplemental Schedule	7,725,253	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,725,253	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,194,091	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,325,382	31
32	Health Care	2,218,062	32
33	General Administration	3,109,591	33
	B. Capital Expense		
34	Ownership	4,479,001	34
	C. Ancillary Expense		
35	Special Cost Centers	1,610,883	35
36	Provider Participation Fee	70,902	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,813,821	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,619,730)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,619,730)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 56,511	44
45	Private Pay - Net Inpatient Revenue	1,895,506	45
46	Medicare - Net Inpatient Revenue	820,734	46
47	Other-(specify) Hospice		47
48	Other-(specify) Private Insurance	126,333	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,899,084	49

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

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

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

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

Facility Name & ID Number	Montgomery Place	#	0037515	Report Period Beginning:	7/1/2015	Ending:	6/30/2016
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SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule

Line 25 Interest and Other Investment Income

Income reported on this line includes changes to the market value of investments and restricted funds.
The investment income related to market value changes and restricted funds has not been offset against interest expense reported on Schedule V, line 32.

Line 28 - Other Revenue

Description	Amount
Independent Living, including amortized entrance fees	\$ 7,293,650
CH Admin Fee & Fee Revenue from HPHCS ¹	36,000
Cell Tower Revenue	51,028
Employee, Music, Library, Resident, and Care Assum Funds	55
Housekeeping Services	13,708
Massage Revenue	3,425
Medical Records Income	
Miscellaneous Income	2,344
Miscellaneous Services	53,260
Room Rental	2,398
Transportation	17,296
Non-Resident Garage	142,219
Gain on Disposal of Fixed Assets	109,870
	<u>\$ 7,725,253</u>

¹ CH - Church Home and HPHCS - Hyde Park Home Care Services

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	1,968	2,080	\$ 119,986	\$ 57.69	1
2	Assistant Director of Nursing	722	862	18,773	21.78	2
3	Registered Nurses	6,639	7,420	287,671	38.77	3
4	Licensed Practical Nurses	14,629	15,765	455,912	28.92	4
5	CNAs & Orderlies	28,734	31,275	490,592	15.69	5
6	CNA Trainees		0	0		6
7	Licensed Therapist		0	0		7
8	Rehab/Therapy Aides		0	0		8
9	Activity Director	1,946	2,080	47,882	23.02	9
10	Activity Assistants	3,781	4,043	44,919	11.11	10
11	Social Service Workers			0		11
12	Dietician	1,448	1,535	31,560	20.56	12
13	Food Service Supervisor	912	920	36,349	39.51	13
14	Head Cook	2,271	2,441	83,726	34.30	14
15	Cook Helpers/Assistants	49,189	52,559	632,802	12.04	15
16	Dishwashers	10,044	10,577	110,001	10.40	16
17	Maintenance Workers	6,631	7,317	168,739	23.06	17
18	Housekeepers	21,481	23,461	292,665	12.47	18
19	Laundry	5,472	5,744	61,620	10.73	19
20	Administrator	1,712	2,093	113,278	54.12	20
21	Assistant Administrator		0	0		21
22	Other Administrative	12,328	13,864	583,859	42.11	22
23	Office Manager					23
24	Clerical	5,752	6,328	111,435	17.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,018	2,200	51,000	23.18	31
32	Other Health Care MDS Coordinator	1,446	1,599	65,335	40.86	32
33	Other(specify) See Supplemental	38,989	42,325	775,714	18.33	33
34	TOTAL (lines 1 - 33)	218,112	236,488	\$ 4,583,818 *	\$ 19.38	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		\$ 11,872	1.3	35
36	Medical Director		32,614	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant		56,414	10.3	38
39	Pharmacist Consultant		733	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		864	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 102,497		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

PG20 Supplement

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

		1	2**	3	4
		# of Hrs.	# of Hrs.	Reporting Period	Average
		Actually	Paid and	Total Salaries,	Hourly
	<u>Description</u>	<u>Worked</u>	<u>Accrued</u>	<u>Wages</u>	<u>Wage</u>
33 A	Marketing	6,730	7,362	\$ 292,865	\$ 39.78
33 B	Transportation	4,768	5,188	41,174	7.94
33 C	Security	8,086	8,670	127,265	14.68
33 D	Activity Director - IL	1,908	2,064	53,087	25.72
33 E	Assisted Living	15,341	16,633	210,883	
33 F	Pastorial	2,156	2,408	50,440	20.95
	Total Line 33	<u>38,989</u>	<u>42,325</u>	<u>\$ 775,714</u>	<u>\$ 18.33</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Sheila Bogen	Administrator	0	\$ 113,278
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 113,278
B. Administrative - Other			
Description			Amount
N/A			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Crowe Horwath LLP	Audit/cost reporting	\$	57,598
ADP	Payroll Processing		43,692
Greenberg Taurig LLP	Legal Services		335,398
Jackson Lewis P.C.	Legal Services		69
Nixon Peabody LLP	Legal Services		46,497
Polsinelli Shughart PC	Legal Services		500
Schiff Hardin LLP	Legal Services		23,181
Sheribel Rothenberg	Legal Services		1,250
Adjustments for accruals and refund deposits			(3,947)
Other	Various accounting svcs		59,572
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 563,810
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	173,442
Unemployment Compensation Insurance			0
FICA Taxes			459,530
Employee Health Insurance			303,816
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			0
Senior Mgmt Benefits Pkg & Bonuses			17,500
Voluntary Benefits			11,009
Life Insurance			22,495
401K Admin Expense			0
Employee Appreciation / Christmas Expense			22,037
Less: Marketing Employee Benefits/PR Taxes			(34,715)
Less: AL/IL Employee Benefits & PR Taxes			(492,144)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 482,970
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
N/A		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	0
Advertising: Employee Recruitment			24,965
Health Care Worker Background Check (Indicate # of checks performed)			745
Patient Background Checks			
Drug Tests			8,882
Dues & Subscriptions			15,822
Licenses / Permit Fees			14,835
Less: Lobbying Expenses			(2,426)
Less: Allocated AL/IL Expenses			(38,790)
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 24,033
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
N/A			
In-State Travel			
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	

*** Attach copy of IMRF notifications**

****See instructions.**

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

Invoice No.	Date	GL Account No.	Payee/Vendor	Amount	Comments	Unallowable Cost
3979866	8/12/2015	105-4462-010	Greenberg Traurig LLP.	13,764.09	Unfair labor practice charge	
3979868	8/12/2015	105-4462-010	Greenberg Traurig LLP.	13,750.00	Complaint investigation	
		105-4462-010	Greenberg Traurig LLP.	3,520.00		3,520.00
4000919	9/4/2015	105-4462-010	Greenberg Traurig LLP.	1,050.27	Employment, labor relations matters	
4000923	9/4/2015	105-4462-010	Greenberg Traurig LLP.	478.50	Employment, labor relations matters	
4000925	9/4/2015	105-4462-010	Greenberg Traurig LLP.	2,827.50	Employment, labor relations matters	
4000927	9/4/2015	105-4462-010	Greenberg Traurig LLP.	2,436.00	Employment, labor relations matters	
4000929	9/4/2015	105-4462-010	Greenberg Traurig LLP.	7,260.00	Unfair labor practice charge	
4000930	9/4/2015	105-4462-010	Greenberg Traurig LLP.	25,009.10	Complaint investigation	
4000931	9/4/2015	105-4462-010	Greenberg Traurig LLP.	7,535.00	Union arbitration	
4031052	10/8/2015	105-4462-010	Greenberg Traurig LLP.	890.00	Employment, labor relations matters	
4031070	10/8/2015	105-4462-010	Greenberg Traurig LLP.	2,968.00	Employment, labor relations matters	
4031072	10/8/2015	105-4462-010	Greenberg Traurig LLP.	348.00	Employment, labor relations matters	
4031074	10/8/2015	105-4462-010	Greenberg Traurig LLP.	3,523.50	Employment, labor relations matters	
4031080	10/8/2015	105-4462-010	Greenberg Traurig LLP.	7,012.50	Complaint investigation	
		105-4462-010	Greenberg Traurig LLP.	8,160.10		8,160.10
		105-4462-010	Greenberg Traurig LLP.	348.00		348.00
		105-4462-010	Greenberg Traurig LLP.	261.00		261.00
		105-4462-010	Greenberg Traurig LLP.	16,112.55		16,112.55
		105-4462-010	Greenberg Traurig LLP.	6,875.00		6,875.00
4085385	12/7/2015	105-4462-010	Greenberg Traurig LLP.	20,807.29	LifeCare@Home employment/labor relations matters	20,807.29
4085388	12/7/2015	105-4462-010	Greenberg Traurig LLP.	391.50	Employment, labor relations matters	
		105-4462-010	Greenberg Traurig LLP.	391.50		391.50
		105-4462-010	Greenberg Traurig LLP.	7,682.50		7,682.50
4107662	1/12/2016	105-4462-010	Greenberg Traurig LLP.	2,145.00	Employment, labor relations matters - MP and LifeCare	1,155.00
4107664	1/12/2016	105-4462-010	Greenberg Traurig LLP.	4,000.50	Employment, labor relations matters	
4107666	1/12/2016	105-4462-010	Greenberg Traurig LLP.	522.00	Employment, labor relations matters	
4107673	1/12/2016	105-4462-010	Greenberg Traurig LLP.	6,158.10	Complaint investigation	
4129956	1/12/2016	105-4462-010	Greenberg Traurig LLP.	68,729.39	Employment, labor relations matters, severance negotiations	
4129948	2/10/2016	105-4462-010	Greenberg Traurig LLP.	4,479.00	Employment, labor relations matters	
4129949	2/10/2016	105-4462-010	Greenberg Traurig LLP.	783.00	Employment, labor relations matters	
4129950	2/10/2016	105-4462-010	Greenberg Traurig LLP.	4,077.52	Employment, labor relations matters	
4155639	3/15/2016	105-4462-010	Greenberg Traurig LLP.	19,507.00	Employment, labor relations matters - LifeCare@Home	19,507.00
4155643	3/15/2016	105-4462-010	Greenberg Traurig LLP.	217.50	Employment, labor relations matters	
4155644	3/15/2016	105-4462-010	Greenberg Traurig LLP.	9,521.40	Employment, labor relations matters	
4155645	3/15/2016	105-4462-010	Greenberg Traurig LLP.	8,068.95	Employment, labor relations matters	
4155650	3/15/2016	105-4462-010	Greenberg Traurig LLP.	7,584.30	Employment, labor relations matters, severance negotiations	
4179320	4/9/2016	105-4462-010	Greenberg Traurig LLP.	21,996.53	Employment, labor relations matters - LifeCare@Home	21,996.53
4179321	4/13/2016	105-4462-010	Greenberg Traurig LLP.	402.64	Employment, labor relations matters	
4179322	4/13/2016	105-4462-010	Greenberg Traurig LLP.	43.50	Employment, labor relations matters	
4179323	4/13/2016	105-4462-010	Greenberg Traurig LLP.	1,275.00	Employment, labor relations matters	
4200151	5/9/2016	105-4462-010	Greenberg Traurig LLP.	3,795.00	Employment, labor relations matters - MP and LifeCare	57.50
4200162	5/9/2016	105-4462-010	Greenberg Traurig LLP.	391.84	Employment, labor relations matters	
4200172	5/9/2016	105-4462-010	Greenberg Traurig LLP.	2,762.50	Employment, labor relations matters - LifeCare@Home	2,762.50
4217909	6/3/2016	105-4462-010	Greenberg Traurig LLP.	9,138.00	Employment, labor relations matters - LifeCare@Home	9,138.00
		105-4462-010	Greenberg Traurig LLP.	6,417.00		6,417.00
			Total Greenberg Traurig LLP	\$ 335,397.65		
6561109	3/31/2015	105-4462-010	Jackson Lewis P.C.,			

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>Yes</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>Leading Age Illinois \$9,704</u>
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?	<u>Yes</u> <u>Yes</u>
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?	<u>No</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>Yes</u> <u>10 - 20</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>17,934</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>Yes</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	YES <u>X</u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	<u>N/A</u>
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.	\$ <u>70,902</u>
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	<u>No</u>
(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?	<u>Yes</u>
(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? 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.	<u>Yes (AL/IL)</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>Yes</u> Indicate the amount. \$ <u>(16,687)</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?	<u>No</u> <u>No</u> \$ <u>N/A</u> <u>Yes</u> <u>N/A</u>
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.	<u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>Yes</u> <u>Crowe Horwath LLP</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?	<u>Yes</u>
(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. Attach invoices and a summary of services for all architect and appraisal fees	<u>Yes</u>