FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0039347

Facility Name: Montgomery Nursing & Rehabilitation Center

Address: South Route 127, P O Box 309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	88	Intermediate (ICF)	88	32,120	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,049	935	4,067	6,051	8
9	SNF/PED					9
10	ICF	17,412	13,469	15	30,896	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,461	14,404	4,082	36,947	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.02%

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? Yes

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 4,067

Medicare Intermediary Pinnacle Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cente # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	237,977	16,373	6,431	260,781		260,781		260,781			1
2	Food Purchase		208,301		208,301		208,301		208,301			2
3	Housekeeping	120,888	16,298		137,186		137,186		137,186			3
4	Laundry	78,662	14,799		93,461		93,461		93,461			4
5	Heat and Other Utilities			106,436	106,436		106,436		106,436			5
6	Maintenance	50,519	6,471	36,141	93,131		93,131	459	93,590			6
7	Other (specify):* Med. Waste/Sanitation			5,156	5,156		5,156		5,156			7
8	TOTAL General Services	488,046	262,242	154,164	904,452		904,452	459	904,911			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,568,346	123,494	53,303	1,745,143		1,745,143		1,745,143			10
10a	Therapy		7,603	488,478	496,081		496,081	(21,707)	474,374			10a
11	Activities	51,208	7,382	895	59,485	(223)	59,262		59,262			11
12	Social Services	37,822	165	895	38,882	(345)	38,537		38,537			12
13	CNA Training			1,088	1,088	220	1,308		1,308			13
14	Program Transportation		9,177		9,177		9,177		9,177			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,657,376	147,821	554,259	2,359,456	(348)	2,359,108	(21,707)	2,337,401			16
	C. General Administration											
17	Administrative	80,833	14,227	267,642	362,702	(6,278)	356,424	(134,763)	221,661			17
18	Directors Fees											18
19	Professional Services			68,918	68,918	6,156	75,074	(47,739)	27,335			19
20	Dues, Fees, Subscriptions & Promotions			69,210	69,210	(60)	69,150	(45,116)	24,034			20
21	Clerical & General Office Expenses	66,811	20,530	75,224	162,565		162,565	33,026	195,591			21
22	Employee Benefits & Payroll Taxes			362,855	362,855		362,855	10,239	373,094			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,850	16,850	530	17,380	847	18,227			24
25	Other Admin. Staff Transportation							2,781	2,781			25
26	Insurance-Prop.Liab.Malpractice			53,304	53,304		53,304	1,941	55,245			26
27	Other (specify):*											27
28	TOTAL General Administration	147,644	34,757	914,003	1,096,404	348	1,096,752	(178,784)	917,968			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,293,066	444,820	1,622,426	4,360,312		4,360,312	(200,032)	4,160,280			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center #0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			138,483	138,483		138,483	1,873	140,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,928	149,928		149,928	(27,844)	122,084			32
33	Real Estate Taxes			53,581	53,581		53,581		53,581			33
34	Rent-Facility & Grounds							11,691	11,691			34
35	Rent-Equipment & Vehicles			4,852	4,852		4,852	1,594	6,446			35
36	Other (specify):* Mortgage Ins.			11,646	11,646		11,646		11,646			36
37	TOTAL Ownership			358,490	358,490		358,490	(12,686)	345,804			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,003	1,003		1,003		1,003			38
39	Ancillary Service Centers		155,402	32,778	188,180		188,180		188,180			39
40	Barber and Beauty Shops		1,979		1,979		1,979		1,979			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		157,381	94,006	251,387		251,387		251,387			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,293,066	602,201	2,074,922	4,970,189		4,970,189	(212,718)	4,757,471			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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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				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	(9,529)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,574)	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	(2,393)	24		19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(803)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(32,515)	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	(9,352)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,366)		$	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)	(151,352)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (151,352)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (212,718)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Montgomery Nursing & Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC dues, including lobbying portion	$ (2,503)	20	1
2	Eliminate 2011/2012 IDPH license paid in 2010	(3,980)	20	2
3	Eliminate depreciation exp. for non-medicaid assets	(2,494)	30	3
4	Eliminate non allowable dues	(375)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,352)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	459	0	0	0	0	0	0	0	0	0	459	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	459	0	0	0	0	0	0	0	0	0	459	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	(21,707)	0	0	0	0	0	0	0	0	(21,707)	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	(21,707)	0	0	0	0	0	0	0	0	(21,707)	16
	C. General Administration													
17	Administrative	0	59,686	(194,449)	0	0	0	0	0	0	0	0	(134,763)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(803)	4,577	(51,513)	0	0	0	0	0	0	0	0	(47,739)	19
20	Fees, Subscriptions & Promotions	(46,147)	1,031	0	0	0	0	0	0	0	0	0	(45,116)	20
21	Clerical & General Office Expenses	0	33,026	0	0	0	0	0	0	0	0	0	33,026	21
22	Employee Benefits & Payroll Taxes	0	10,239	0	0	0	0	0	0	0	0	0	10,239	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,393)	3,240	0	0	0	0	0	0	0	0	0	847	24
25	Other Admin. Staff Transportation	0	2,781	0	0	0	0	0	0	0	0	0	2,781	25
26	Insurance-Prop.Liab.Malpractice	0	1,941	0	0	0	0	0	0	0	0	0	1,941	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,343)	116,521	(245,962)	0	0	0	0	0	0	0	0	(178,784)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,343)	116,980	(267,669)	0	0	0	0	0	0	0	0	(200,032)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(2,494)	4,367	0	0	0	0	0	0	0	0	0	1,873	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,529)	0	(18,315)	0	0	0	0	0	0	0	0	(27,844)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,691	0	0	0	0	0	0	0	0	0	11,691	34
35	Rent-Equipment & Vehicles	0	1,594	0	0	0	0	0	0	0	0	0	1,594	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,023)	17,652	(18,315)	0	0	0	0	0	0	0	0	(12,686)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,366)	134,632	(285,984)	0	0	0	0	0	0	0	0	(212,718)	45

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr., Inc.	Jerseyville, IL	Wellington Mgt. Co.	Chesterfield, MO	Management Co.
David L. Kamler	20.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	20.00	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. [X] 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%	$ 459	$ 459	1
2	V	17	See Schedule VIII		Wellington Management Company	60.00%	59,686	59,686	2
3	V	19	See Schedule VIII		Wellington Management Company	60.00%	4,577	4,577	3
4	V	20	See Schedule VIII		Wellington Management Company	60.00%	1,031	1,031	4
5	V	21	See Schedule VIII		Wellington Management Company	60.00%	33,026	33,026	5
6	V	22	See Schedule VIII		Wellington Management Company	60.00%	10,239	10,239	6
7	V	24	See Schedule VIII		Wellington Management Company	60.00%	3,240	3,240	7
8	V	25	See Schedule VIII		Wellington Management Company	60.00%	2,781	2,781	8
9	V	26	See Schedule VIII		Wellington Management Company	60.00%	1,941	1,941	9
10	V	30	See Schedule VIII		Wellington Management Company	60.00%	4,367	4,367	10
11	V	34	See Schedule VIII		Wellington Management Company	60.00%	11,691	11,691	11
12	V	35	See Schedule VIII		Wellington Management Company	60.00%	1,594	1,594	12
13	V								13
14	Total			$			$ 134,632	$ * 134,632	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	10	Nursing and Medical Records	$ 28,978	Wellington Management Company	60.00%	$ 28,978	$	15
16	V	17	Management Fees	189,491	Wellington Management Company	60.00%		(189,491)	16
17	V	17	Management Fees	78,151	Health Care Financial, LLC	40.00%	73,193	(4,958)	17
18	V	19	Professional Services	51,513	C.J. Schlosser & Company, LLC	40.00%		(51,513)	18
19	V	10a	Therapy Services	488,478	NW Rehab, LLC	100.00%	466,771	(21,707)	19
20	V	32	Interest	10,715	John H. Rothert	60.00%		(10,715)	20
21	V	32	Interest	3,800	J. Terry Dooling	20.00%		(3,800)	21
22	V	32	Interest	3,800	David L. Kamler	20.00%		(3,800)	22
23	V	21	Clerical	16,381	Wellington Management Company	60.00%	16,381		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			$ 871,307			$ 585,323	$ * (285,984)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cent # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	255,481	7.56	18.89	Salary	$ 59,519	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	$ 59,519		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 Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Accumulated Costs	22,320,474	6	$ 2,431	$	4,217,433	$ 459	1
2	17	Administrative	Accumulated Costs	22,320,474	6	315,886	315,886	4,217,433	59,686	2
3	19	Professional Services	Accumulated Costs	22,320,474	6	24,222		4,217,433	4,577	3
4	20	Dues, Fees, Subs, & Promos	Accumulated Costs	22,320,474	6	5,455		4,217,433	1,031	4
5	21	Clerical & General Office Exp.	Accumulated Costs	22,320,474	6	174,786	106,027	4,217,433	33,026	5
6	22	Employee Benefits & PR Taxes	Accumulated Costs	22,320,474	6	54,187		4,217,433	10,239	6
7	24	Travel & Seminar	Accumulated Costs	22,320,474	6	17,147		4,217,433	3,240	7
8	25	Other Admin Staff Transport	Accumulated Costs	22,320,474	6	14,717		4,217,433	2,781	8
9	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	22,320,474	6	10,275		4,217,433	1,941	9
10	30	Depreciation	Accumulated Costs	22,320,474	6	23,109		4,217,433	4,366	10
11	34	Rent - Facility & Ground	Accumulated Costs	22,320,474	6	61,875		4,217,433	11,691	11
12	35	Rent - Equipment & Vehicles	Accumulated Costs	22,320,474	6	8,439		4,217,433	1,595	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					$ 712,529	$ 421,913		$ 134,632	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Cente # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkadia		X	Refinance Mortgage	$13,209.94	11/30/06	$ 2,415,500	$ 2,314,526	11/30/41	5.6500	$ 130,221	1
2												2
3									Loan Cost Amortization		1,392	3
4									Interest Income		(9,529)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$13,209.94		$ 2,415,500	$ 2,314,526			$ 122,084	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	$ 2,314,526			$ 122,084	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,646 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.)

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 49,000	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.)		$ 50,581	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,581	3
4. Real Estate Tax accrual used for 2010 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.		$ 53,581	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	40,644	8
	2006	40,988	9
	2007	44,524	10
	2008	47,841	11
	2009	50,581	12

Line 2 : 2009 Taxes Paid

Line 4 : Accrual is based on 2009 taxes paid plus 3% rounded to nearest $1,000.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing & Rehabilitation Center 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-13-379-001	NE PT SE SW Land Corp Limit	$ 50,580.92	$ 50,580.92
2.		Taylor Springs 8-4-716 3/4 S13	$	$
3.		T08 R4	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,580.92	$ 50,580.92

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 962,086	$ 38,483	25	$ 38,483	$	$ 644,598	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed			1994	3,247		10			3,247	9
10	Air Conditioner			1994	76,140		10			76,140	10
11	Cabinets			1994	6,809	340	20	340		5,533	11
12	Doors			1994	2,337	117	20	117		1,908	12
13	Electrical			1994	4,601	230	20	230		3,715	13
14	Flooring			1994	25,850		10			25,850	14
15	Exterior Remodeling			1994	4,468		15			4,468	15
16	Interior Remodeling			1994	66,214		15			66,214	16
17	Nurse Call System			1994	1,960		15			1,960	17
18	Plumbing			1994	6,619	331	20	331		5,369	18
19	Roof			1994	29,619		10			29,619	19
20	Windows/Gutters			1994	60,254		15			60,254	20
21	Siding			1994	15,818		15			15,818	21
22	Landscaping			1994	3,134		10			3,134	22
23	Parking Lot			1994	29,107		10			29,107	23
24	Flooring			1995	938		10			938	24
25	Metal Doors and Frames			1996	953	48	20	48		691	25
26	Metal Carport			1997	972	65	15	65		859	26
27	Carpet			1997	2,310		5			2,310	27
28	Dining Room Chair Rail			1997	2,230	149	15	149		1,933	28
29	Wallpapering			1997	4,830		5			4,830	29
30	Fire Doors			1997	593	30	20	30		385	30
31	Foilage & Fountain			1997	1,657		10			1,657	31
32	Interior Painting			1997	514		5			514	32
33	Shed			1997	315		10			315	33
34	Door Alarm System			1997	7,840		10			7,840	34
35	Sidewalk Replacement			1997	650	43	15	43		567	35
36	Beauty Shop Remodeling			1998	4,287	214	20	214		2,626	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Wallpapering	1998	$ 1,493	$	5	$	$	$ 1,493	37
38	Shower Room Remodeling	1998	1,199	60	20	60		740	38
39	Mini Blinds Installed	1998	509		10			509	39
40	Shelving	1998	566	28	20	28		351	40
41	Baseboard Remodeling	1998	820		10			820	41
42	Water Heater	1998	6,040	403	15	403		4,933	42
43	Folding Doors	1998	456		10			456	43
44	Door Installed	1998	208		10			208	44
45	Wall Mounted Laundry Tub	1998	181	9	20	9		117	45
46	Shower Flooring	1998	401		10			401	46
47	Shed	1998	185		10			185	47
48	Flooring	1998	293		10			293	48
49	Air Conditioning Unit	2000	557	23	10	23		557	49
50	Asphalt Parking Lot	2000	2,360	157	10	157		2,360	50
51	Fire Doors	2001	1,535	102	15	102		981	51
52	Signage	2001	3,318		5			3,318	52
53	Cove Base	2001	1,006	101	10	101		962	53
54	Window Treatments	2001	7,272		5			7,272	54
55	Wallpapering	2001	37,693		5			37,693	55
56	Lobby Carpet	2001	1,433		5			1,433	56
57	Air Conditioning Unit	2001	1,696	170	10	170		1,611	57
58	Cove Base	2002	604	60	10	60		494	58
59	Wallpapering	2002	4,462		5			4,462	59
60	Air Conditioning Unit	2002	1,446	20	10	20		1,539	60
61	Blinds	2002	512		5			512	61
62	Flooring & Cove Base	2002	1,630	163	10	163		1,453	62
63	Wall Guard	2002	1,927	128	15	128		1,135	63
64	Fire Doors	2002	1,042	69	15	69		590	64
65	A/C/Heat Pump Units	2002	1,580	158	10	158		1,330	65
66	Air Conditioning Unit	2003	3,110	311	10	311		2,295	66
67	11 Fire Doors	2003	5,950	397	15	397		2,876	67
68	Home Office Cabinets	2003	788		15	78	78	591	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,418,624	$ 42,409		$ 42,487	$ 78	$ 1,086,369	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 Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 1,418,624	$ 42,409		$ 42,487	$ 78	$ 1,086,369	1
2	Closet Doors - Resident Rooms	2004	3,628	242	15	242		1,574	2
3	Wiring Outside Lights	2004	1,145	57	20	57		396	3
4	Tile	2004	878	88	10	88		607	4
5	Commercial Water Heater	2004	7,664	766	10	766		4,981	5
6	Floor Tile	2004	1,186	119	10	119		722	6
7	66 Gallon Water Heater	2004	931	93	10	93		566	7
8	Patio & Sidewalks	2004	14,316	954	15	954		6,045	8
9	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		659	9
10	Gravel Parking Lot	2004	3,355		5			3,355	10
11	Range Hood	2005	832	42	20	42		249	11
12	Closet Doors - Resident Rooms	2005	3,689	369	10	369		2,130	12
13	Outside Light Fixtures	2005	2,025	203	10	203		1,157	13
14	Air Conditioning Unit	2005	7,610	761	10	761		4,156	14
15	Generator Wiring	2005	1,660	166	5	166		1,660	15
16	Electrical Work	2005	5,528	276	20	276		1,520	16
17	Tile & Cove Base	2005	2,064	206	10	206		1,118	17
18	Heating/Cooling Unit	2005	558	65	5	65		558	18
19	Wallpaper	2005	811	122	5	122		811	19
20	Therapy Room Cabinets	2005	1,200	80	15	80		400	20
21	New Roof - 200 & 500 Wings	2005	74,745	4,983	15	4,983		26,161	21
22	Wall Guard	2006	570	38	15	38		184	22
23	6 Oak Doors	2006	3,469	231	15	231		1,060	23
24	Smoke Detectors	2006	683	68	10	68		319	24
25	Exhaust Fans for Kitchen	2006	1,034	103	10	103		440	25
26	New Roof - 300 Wing	2007	30,200	3,020	10	3,020		11,577	26
27	Shower & Wall Remodel	2006	5,510	276	20	276		1,079	27
28	Water Heaters	2006	1,695	170	10	170		772	28
29	Air Conditioning Unit	2006	3,414	580	5-10	580		2,597	29
30	Storage Shed	2006	1,583	158	10	158		719	30
31	Fire Doors	2006	4,939	329	15	329		1,372	31
32	Patio & Sidewalks	2006	9,566	638	15	638		2,874	32
33	Exhaust Fan Replacement	2007	3,862	386	10	386		1,223	33
34	TOTAL (lines 1 thru 33)		$ 1,620,494	$ 58,099		$ 58,177	$ 78	$ 1,169,410	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 1,620,494	$ 58,099		$ 58,177	$ 78	$ 1,169,410	1
2	Interior Remodeling - Shower Room	2007	20,896	1,045	20	1,045		3,427	2
3	Water Heaters	2007	10,972	1,097	10	1,097		4,117	3
4	Doors-Metal	2007	4,450	223	20	223		810	4
5	Air Conditioning Units	2007	3,512	702	5	702		2,376	5
6	Flooring	2007	10,399	1,040	10	1,040		3,374	6
7	Landscaping - Sign Area	2007	2,575	258	10	258		923	7
8	Repaved Driveway	2007	4,750	594	8	594		2,029	8
9	Flooring	2008	132,076	13,208	10	13,208		33,892	9
10	Wallpapering	2008	45,923	9,185	5	9,185		24,020	10
11	Electrical Work	2008	11,765	588	20	588		1,513	11
12	5 A/C Units & Installation	2008	8,021	802	10	802		2,073	12
13	Facility Signage	2008	8,602	1,720	5	1,720		4,224	13
14	8 Oak Doors	2008	4,659	311	15	311		724	14
15	In Wall Fountain - Labor & Materials	2008	5,321	760	7	760		1,900	15
16	Handrails & Hardware	2008	8,950	597	15	597		1,641	16
17	Cabinets, Countertops, & Sinks	2008	28,200	1,880	15	1,880		5,170	17
18	5 Shaped Cornices	2008	3,034	303	10	303		708	18
19	Cabinet Installation	2008	3,320	221	15	221		479	19
20	3 A/C Units	2008	1,839	368	5	368		551	20
21	Sinks/Faucets - Resident Rooms	2009	2,985	149	20	149		183	21
22	Generator	2009	50,432	2,522	20	2,522		4,623	22
23	Roof Replacement - 100 & 400 Halls	2009	36,200	3,620	10	3,620		6,033	23
24	10 Upholstered Cornices	2009	5,255	526	10	526		963	24
25	Wi-Fi Access Installation	2009	1,893	95	20	95		142	25
26	130 Gallon Water Heater	2009	12,707	1,271	10	1,271		1,906	26
27	Ceiling Tiles - Therapy Room	2009	676	68	10	68		90	27
28	Plexiglass for Maint. Shed	2009	759	76	10	76		89	28
29	Closet Doors	2009	548	55	10	55		64	29
30	Home Office Shelving	2009	90		15	6	6	10	30
31	Home Office Carpet	2009	708		5	141	141	259	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,052,011	$ 101,383		$ 101,608	$ 225	$ 1,277,723	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12C, Carried Forward		$ 2,052,011	$ 101,383		$ 101,608	$ 225	$ 1,277,723	1
2	Home Office Suite 140 Labor & Tenant Finish	2009	3,759		20	188	188	329	2
3	New Entry Door	2010	3,000	175	10	175		175	3
4	4 A/C/Heat Units	2010	2,618	172	5	172		172	4
5	New 400 amp Breaker	2010	1,787	49	15	49		49	5
6	Flooring	2010	5,340	38	10	38		38	6
7	Insulate Duct Work	2010	14,800		15				7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,083,315	$ 101,817		$ 102,230	$ 413	$ 1,278,486	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 335,544	$ 27,206	$ 28,973	$ 1,767	5-20 yrs	$ 147,789	71
72	Current Year Purchases	93,064	5,991	5,991		5-20 yrs	5,991	72
73	Fully Depreciated Assets	372,362	977	977		5-10 yrs	372,363	73
74								74
75	TOTALS	$ 800,970	$ 34,174	$ 35,941	$ 1,767		$ 526,143	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2004 Ford Wheelchair Van	2004	$ 35,799	$	$	$	4	$ 35,799	76
77	See attached schedule			19,896		2,185	2,185	4	8,852	77
78										78
79										79
80	TOTALS			$ 55,695	$	$ 2,185	$ 2,185		$ 44,651	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)	$	2,967,653	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	135,991	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	140,356	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	4,365	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,849,280	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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☒ N/A ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,446 Description: Postage Machine $765; Copier $4,087; Home Office Vehicle Lease $1,594
(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

* 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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,560		7,560
6	Transportation				
7	Contractual Payments		480		480
8	CNA Competency Tests		828		828
9	TOTALS	$	$ 8,868	$	$ 8,868
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,868			

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	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	20

(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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 8	5035	hrs	$ 174,426		$	$ 361	5,035	$ 174,787	1
2	Licensed Speech and Language Development Therapist	10a, 8	2394	hrs	109,559				2,394	109,559	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 8	4701	hrs	182,786			7,242	4,701	190,028	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				155,402		155,402	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): X-Rays	39, 3					6,327			6,327	12
13	Other (specify): Lab Fees, Spec. Mattre	39, 3 39, 3					17,844 8,607			8,607	13
14	TOTAL				$ 466,771		$ 32,778	$ 163,005	12,130	$ 644,710	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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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	$ 413,623	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	435,136		3
4	Supply Inventory (priced at)	16,144		4
5	Short-Term Investments			5
6	Prepaid Insurance	30,836		6
7	Other Prepaid Expenses	1,916		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 897,655	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	102,378		13
14	Buildings, at Historical Cost	2,045,095		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	804,279		16
17	Accumulated Depreciation (book methods)	(1,840,007)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	158,444		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	43,022		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,333,411	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,231,066	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 625,925	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,495		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,177		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	227,525		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,104,122	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,793		39
40	Mortgage Payable	2,357,200		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)**	$ 2,549,993	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,654,115	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,423,049)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,231,066	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,775,298)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,775,298)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	352,249	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 352,249	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)**	$ (1,423,049)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,810,695	1
2	Discounts and Allowances for all Levels	(190,084)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,620,611	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	661,425	6
7	Oxygen	2,430	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 663,855	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	16,505	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	9,101	19
20	Radiology and X-Ray	2,466	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,529	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,529	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscelaneous Income	371	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 371	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,322,438	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	904,452	31
32	Health Care	2,359,456	32
33	General Administration	1,096,404	33
	B. Capital Expense		
34	Ownership	358,490	34
	C. Ancillary Expense		
35	Special Cost Centers	191,162	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,970,189	40
41	**Income before Income Taxes (line 30 minus line 40)****	352,249	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 352,249	43

* **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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,990	2,179	$ 67,741	$ 31.09	1
2	Assistant Director of Nursing	1,894	2,140	48,633	22.73	2
3	Registered Nurses	5,053	5,451	114,812	21.06	3
4	Licensed Practical Nurses	23,223	25,017	417,535	16.69	4
5	CNAs & Orderlies	90,512	95,681	898,666	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,173	5,548	51,208	9.23	10
11	Social Service Workers	1,929	2,126	37,822	17.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,661	25,186	237,976	9.45	15
16	Dishwashers					16
17	Maintenance Workers	3,026	3,373	50,519	14.98	17
18	Housekeepers	12,411	13,304	120,888	9.09	18
19	Laundry	8,955	9,636	78,662	8.16	19
20	Administrator	1,810	2,080	80,833	38.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,228	3,833	66,811	17.43	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	1,987	2,148	20,960	9.76	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,852	197,702	$ 2,293,066 *	$ 11.60	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	110	$ 6,431	1, 3	35
36	Medical Director	Contract	9,600	9, 3	36
37	Medical Records Consultant	14	784	10, 3	37
38	Nurse Consultant			10, 3	38
39	Pharmacist Consultant	Contract	5,322	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	550	11, 3	44
45	Social Service Consultant	9	550	12, 3	45
46	Other(specify) Compliance Consultir	24	1,838	10, 3	46
47	Quality Assurance Nurse	N/A	28,978	10, 3	47
48	Clerical	N/A	16,381	21, 3	48
49	TOTAL (lines 35 - 48)	166	$ 70,434		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carla Vonder Haar	Administrator		$ 80,833
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,833

B. Administrative - Other

Description	Amount
Wellington Management Co. - Management Fees	$ 189,491
Health Care Financial, LLC - Management Fees	78,151
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 267,642

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co., LLC	Accounting Services	$ 51,513
May, Cocagne, & King	Audit Fees	12,050
Duane Morris	Legal Services	2,317
Sandberg Phoenix & von Gontard P.(	Legal Services	1,347
Burnside, Johnston, Sheafor & Kelly	Collection Fees (eliminated)	803
Husch Blackwell Sanders, LLP	Legal Services	664
Droege & Associates	401(k) Audit	224
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 68,918

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,619
Unemployment Compensation Insurance	41,297
FICA Taxes	162,453
Employee Health Insurance	55,976
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	16,910
Employee Dental/Vision Insurance	1,824
Home Office Employee Benefits	10,239
Employee Deductible Reimb. Expense	11,268
Employee Life/Disability Insurance	2,394
Employee Physicals	114
TOTAL (agree to Schedule V, line 22, col.8)	$ 373,094

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,943
Health Care Worker Background Check	
(Indicate # of checks performed 17)	272
Patient Background Checks 71	1,136
Dues, Subscriptions, & Manuals	5,549
Licenses & Fees	1,381
Bank Service Charges	2,625
IHCA Dues	4,097
Home Office Dues, Fees, Subscriptions	1,031
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,034

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,677
Seminar Expense	9,310
Home Office Travel & Seminar	3,240
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,227

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

Facility Name & ID Number Montgomery Nursing & Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 $4097**

(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. $ **13,586** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,225**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **43.74%**
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 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.

MONTGOMERY NURSING & REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/2010

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(6,278)
ACTIVITIES	11	122
PROFESSIONAL SERVICES	19	6,156
To reclass various expenses to proper lines		
TRAVEL & SEMINAR	24	(160)
NURSE AIDE TRAINING	13	160
To reclass C.N.A. Evaluator to the correct line		
TRAVEL & SEMINAR	24	690.00
ACTIVITIES	11	(345.00)
SOCIAL SERVICES	12	(345.00)
To reclass seminar expenses to the correct line		
DUES, FEES, SUBSCRIPTIONS, AND PROMOS	20	(60.00)
NURSE AIDE TRAINING	13	60.00
To reclass C.N.A. book expense to the correct line		

Montgomery Nursing & Rehab Center
Attachment to Sch. XI, Part D
December 31, 2010

Detail of Line 79: Home Office Admin Vehicles

Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life In Years	Accumulated Depreciation
2000 Taurus	2000	4,500	-	-	-	4	4,500
2008 Hyundai Sonata	2008	3,211	-	803	803	4	2,074
2003 Infiniti I-35	2008	3,309	-	827	827	4	1,723
2008 Land Rover	2010	8,876	-	555	555	4	555
		19,896	-	2,185	2,185		8,852

Montgomery Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2010

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	$	352,249
CONVERSION TO CASH BASIS ADJUSTMENTS		198,486
SUBTOTAL		550,735
DEPRECIATION ADJUSTMENT		(27,671)
MISC. NON-DEDUCTIBLE EXPENSE		36,267
TAX NET INCOME (LOSS), PER FEDERAL RETURN	$	559,331

MONTGOMERY NURSING & REHAB CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2010

Seminar Participant	Job Title	Dates	City	Title of Seminar	Sponsor	Cost	Seminar Lodging Travel/Meals
Ramona Tomazzoli & Debbie Schulte	DON, ADON	12/7/09-12/8/09	Hillsboro, IL	Risk Watch Training	Risk Watch International	576	
Carla Vonder Haar, Ramona Tomazzoli, Deb Schulte	Administrator, DON, ADON	2/25/2010	Springfield, IL	Public Health Tag Seminar	Illinois Health Care Association	285	126
John Rothert, Terrry Dooling, Holly Jensen	President, Treasurer, Billing	5/24/2010	St. Louis, MO	MDS 3.0 for Management	Missouri League for Nursing, Inc	81	
Amy Elik, Cindy Tefteller	Corporate Accountants	5/24/2010	St. Louis, MO	MDS 3.0 for Management	Missouri League for Nursing, Inc		
Robin White	Quality Assurance Nurse	6/1/2010	Springfield, IL	QM/QI Troubleshooter	Illinois Nursing Home Administrators Assoc.	164	
John Rothert, Terrry Dooling	President, Treasurer	10/19/2010	St. Louis, MO	National Health Care Reform	Missouri Association of Nursing Home Administrators	38	
Robin White, Lisa Yates	Quality Assurance Nurse, LPN from JNRC	10/18-10/22/10	Brookfield, WI	MDS 3.0 Resident Assessment Coordinator Certification	Amercian Association of Nurse Assessment Coordinators	712	
Alicia Geninatti, Pam Jones	Activites Asst., Activity Director	10/20-10/22/10	Springfield, IL	2010 IAPA Conference	Illinois Activitiy Professionals Association	550	495
Carla Vonder Haar, Shannon Moore, Tammy Richmond, Julie Prickett	Administrator, Care Plan Coord., Soc Svcs Director, Therapy Manager	6/23/2010	Springfield, IL	MDS 3.0 Seminar	Illinois Health Care Association	660	78
Debbie Schulte, Stacey Roach	ADON, Care Plan Coordinator	1/19/2011	Effingham, IL	MDS 3.0 Seminar	Illinois Health Care Association	350	64
Sarah Laurent	Registered Nurse	4/16/2010	Springfield, IL	2010 C.N.A Instructor Conference	Lincoln Land Community College	80	
Dana Waugh	Registered Nurse	11/15-11/19/10	Springfield, IL	C.N.A. Instructor Course for RN's	Lincoln Land Community College	450	
Carla Vonder Haar, Ramona Tomazzoli	Administrator, DON	11/2-11/3/10	Springfield, IL	2010 Annual Convention & Trade Show	Illinois Nursing Home Administrators Assoc.	250	149
Tera Scroggins	Registered Nurse	Various	N/A	Class Tuition - R.N. Courses	Sandford Brown College	1005	
Pam Jones	Activity Director	Various	Springfield, IL	Activity Directors Course	Outcome Services of Illinois, Inc.	360	444
Carla Vonder Haar, Tammy Richmond, Pam Jones	Administrator, Soc Svcs Director, Activity Director	9/3/2010	Springfield, IL	MDS 3.0 Training	Outcome Services of Illinois, Inc.	330	38
Cathy Brummet, Sarah Laurent, Tammy Richmond	Dietary Supervisor, R.N./MDS Coordinator, Social Services Director	Various	Montgomery, IL	MDS 3.0 Training	Illinois Health Care Association	495	
						6386	1394

Total Seminar Lodging/Travel/Meals	1394
CPR Training	480
Online CPE Service for Nurses	1050
Other Travel Expenses <$250	5677
Home Office Travel & Seminar	3240
Total Travel & Seminar, Line 24	18227