		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: 0037515

Facility Name: Montgomery Place

Address: 5550 South Shore Drive (Number) Chicago (City) 60637 (Zip Code)

County: Cook

Telephone Number: (773) 753-4100 **Fax #** (773) 752-0056

HFS ID Number:

Date of Initial License for Current Owners: 01/24/1992

Type of Ownership:

X	**VOLUNTARY,NON-PROFIT**		**PROPRIETARY**		**GOVERNMENTAL**

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

IRS Exemption Code 501(C)(3)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07-01-2009 to 06-30-2010 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)	Mary Von Goeben
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Scott E. Martin, CPA Reimbursement Director
	(Firm Name & Address)	Crowe Horwath LLP 330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46634
	(Telephone)	(574) 232-3992 Fax # (574) 236-8692

In the event there are further questions about this report, please contact:
Name: Scott E. Martin, CPA Telephone Number: (574) 236-7637
Email Address:

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	40	Skilled (SNF)	40	14,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	40	TOTALS	40	14,600	7

B. Census-For the entire report period.

	1	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	1,655	7,153	4,680	13,488	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,655	7,153	4,680	13,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.38%

D. How many bed-hold days during this year were paid by the Department? ____________ (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)
No

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 1/28/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ____________ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 4,316

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2010 Fiscal Year: 6/30/2010

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

Facility Name & ID Number: Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	697,795	103,006	7,816	808,617		808,617	(519,585)	289,032			1
2	Food Purchase		512,846		512,846		512,846	(345,857)	166,989			2
3	Housekeeping	242,802	57,219	9,629	309,650		309,650	(300,941)	8,709			3
4	Laundry	44,405	13,156	684	58,245		58,245	(10,074)	48,171			4
5	Heat and Other Utilities			513,616	513,616		513,616	(499,067)	14,549			5
6	Maintenance	251,034	6,193	320,171	577,398		577,398	(373,121)	204,277			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,236,036	692,420	851,916	2,780,372		2,780,372	(2,048,645)	731,727			8
	B. Health Care and Programs											
9	Medical Director			26,091	26,091		26,091		26,091			9
10	Nursing and Medical Records	1,122,351	57,182	16,104	1,195,637		1,195,637		1,195,637			10
10a	Therapy		1,681	524,763	526,444		526,444		526,444			10a
11	Activities	72,156	1,894	16,465	90,515		90,515		90,515			11
12	Social Services	39,305			39,305		39,305		39,305			12
13	CNA Training											13
14	Program Transportation	43,011	164	10,353	53,528		53,528	(39,632)	13,896			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,276,823	60,921	593,776	1,931,520		1,931,520	(39,632)	1,891,888			16
	C. General Administration											
17	Administrative					97,258	97,258	(62,849)	34,409			17
18	Directors Fees											18
19	Professional Services			169,549	169,549	(11,493)	158,056	(107,478)	50,578			19
20	Dues, Fees, Subscriptions & Promotions			31,254	31,254	11,493	42,747	(28,638)	14,109			20
21	Clerical & General Office Expenses	732,794	23,864	254,095	1,010,753	(97,258)	913,495	(635,654)	277,841			21
22	Employee Benefits & Payroll Taxes			1,071,214	1,071,214		1,071,214	(558,794)	512,420			22
23	Inservice Training & Education			12,129	12,129		12,129	(7,838)	4,291			23
24	Travel and Seminar			10,696	10,696		10,696	(7,121)	3,575			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			196,315	196,315		196,315	(190,716)	5,599			26
27	Other (specify):*			49,616	49,616		49,616	(49,616)				27
28	**TOTAL General Administration**	732,794	23,864	1,794,868	2,551,526		2,551,526	(1,648,704)	902,822			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,245,653	777,205	3,240,560	7,263,418		7,263,418	(3,736,981)	3,526,437			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,323,968	2,323,968		2,323,968	(1,950,824)	373,144			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,999,041	1,999,041		1,999,041	(1,942,024)	57,017			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,990	32,990		32,990	(21,318)	11,672			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,355,999	4,355,999		4,355,999	(3,914,166)	441,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,438	19,355	169,793		169,793		169,793			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			7,690	7,690		7,690		7,690			42
43	Other (specify):*	364,248	52,004	691,368	1,107,620		1,107,620	(1,107,620)				43
44	**TOTAL Special Cost Centers**	364,248	202,442	718,413	1,285,103		1,285,103	(1,107,620)	177,483			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,609,901	979,647	8,314,972	12,904,520		12,904,520	(8,758,767)	4,145,753			45

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

Part V - Reclassifications

	Amount	From Line	To Line
HUB service fee	11,493	19	20
Administrator wages	97,258	21	17

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(44,973)	2		4
5	Telephone, TV & Radio in Resident Rooms	(89,931)	21		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				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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	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	(65,154)	27		24
25	Fund Raising, Advertising and Promotional				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	(8,558,509)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,758,767)		$	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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,758,767)		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

STATE OF ILLINOIS

Montgomery Place

ID# 0037515

Report Period Beginning: 07-01-2009

Ending: 06-30-2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL Dietary Costs	$ (519,585)	1	1
2	AL/IL Food Purchases	(300,191)	2	2
3	Rev Offset - Vending	(693)	2	3
4	AL/IL Housekeeping	(296,632)	3	4
5	Rev Offset - Housekeeping	(4,309)	3	5
6	Rev Offset - Laundry	(10,074)	4	6
7	AL/IL Heat & other utilities	(495,521)	5	7
8	Rev Offset - Misc Svcs	(3,546)	5	8
9	AL/IL Maintenance	(373,121)	6	9
10	AL/IL Transportation	(25,381)	14	10
11	Rev Offset - Transportation	(14,251)	14	11
12	AL/IL Administrator	(62,849)	17	12
13	AL/IL Professional Svc	(92,383)	19	13
14	Unallowable/Unsupported Legal	(15,095)	19	14
15	AL/IL Dues, Fees, Subs	(25,772)	20	15
16	AL/IL Office & Clerical	(507,489)	21	16
17	Rev Offset - Admin Fees	(36,000)	21	17
18	Music Fund Expenses	(240)	21	18
19	Library Fund Expenses	(1,994)	21	19
20	AL/IL Employee Benefits	(443,489)	22	20
21	Marketing Employee Benefits	(55,662)	22	21
22	ILU Specific employee Benefits	(59,643)	22	22
23	AL/IL Inservice	(7,838)	23	23
24	AL/IL Travel & Seminar	(6,529)	24	24
25	Unsupported travel & seminar	(592)	24	25
26	AL/IL Insurance	(190,716)	26	26
27	Late Fees/Service chgs	(4,266)	27	27
28	Prior Year Items	20,004	27	28
29	AL/IL Equip depn	(1,950,824)	30	29
30	AL/IL Interest	(1,942,006)	32	30
31	Interest exp on sec deposits	(18)	32	31
32	AL/IL Equip rental	(21,318)	35	32
33	ILU Specific Expenses	(212,255)	43	33
34	Marketing Expenses	(895,365)	43	34
35	AL/IL LSN Expenses	(2,866)	20	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**	(8,558,509)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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

	Operating Expenses A. General Services	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)	
1	Dietary	(519,585)	0	0	0	0	0	0	0	0	0	0	(519,585)	1
2	Food Purchase	(345,857)	0	0	0	0	0	0	0	0	0	0	(345,857)	2
3	Housekeeping	(300,941)	0	0	0	0	0	0	0	0	0	0	(300,941)	3
4	Laundry	(10,074)	0	0	0	0	0	0	0	0	0	0	(10,074)	4
5	Heat and Other Utilities	(499,067)	0	0	0	0	0	0	0	0	0	0	(499,067)	5
6	Maintenance	(373,121)	0	0	0	0	0	0	0	0	0	0	(373,121)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,048,645)	0	0	0	0	0	0	0	0	0	0	(2,048,645)	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	(39,632)	0	0	0	0	0	0	0	0	0	0	(39,632)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(39,632)	0	0	0	0	0	0	0	0	0	0	(39,632)	16
	C. General Administration													
17	Administrative	(62,849)	0	0	0	0	0	0	0	0	0	0	(62,849)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(107,478)	0	0	0	0	0	0	0	0	0	0	(107,478)	19
20	Fees, Subscriptions & Promotions	(28,638)	0	0	0	0	0	0	0	0	0	0	(28,638)	20
21	Clerical & General Office Expenses	(635,654)	0	0	0	0	0	0	0	0	0	0	(635,654)	21
22	Employee Benefits & Payroll Taxes	(558,794)	0	0	0	0	0	0	0	0	0	0	(558,794)	22
23	Inservice Training & Education	(7,838)	0	0	0	0	0	0	0	0	0	0	(7,838)	23
24	Travel and Seminar	(7,121)	0	0	0	0	0	0	0	0	0	0	(7,121)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(190,716)	0	0	0	0	0	0	0	0	0	0	(190,716)	26
27	Other (specify):*	(49,616)	0	0	0	0	0	0	0	0	0	0	(49,616)	27
28	**TOTAL General Administration**	(1,648,704)	0	0	0	0	0	0	0	0	0	0	(1,648,704)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,736,981)	0	0	0	0	0	0	0	0	0	0	(3,736,981)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,950,824)	0	0	0	0	0	0	0	0	0	0	(1,950,824)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,942,024)	0	0	0	0	0	0	0	0	0	0	(1,942,024)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(21,318)	0	0	0	0	0	0	0	0	0	0	(21,318)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,914,166)	0	0	0	0	0	0	0	0	0	0	(3,914,166)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,107,620)	0	0	0	0	0	0	0	0	0	0	(1,107,620)	43
44	**TOTAL Special Cost Centers**	(1,107,620)	0	0	0	0	0	0	0	0	0	0	(1,107,620)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,758,767)	0	0	0	0	0	0	0	0	0	0	(8,758,767)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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
N/A	N/A	N/A	N/A	Hyde Park Home	Hyde Park	Home Health
				Care		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 [X] 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: 07-01-2009 Ending: 06-30-2010

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 07-01-2009 Ending: 6-30-2010

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 [ ] NO [X]

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

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

	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	1	Dietary	Meals	113,205	2	$ 808,617	$ 697,795	40,464	$ 289,032	1
2	2	Food	Meals	113,205	2	512,846		40,464	183,312	2
3	3	Housekeeping	Square Feet	203,488	2	309,650	242,802	5,804	8,832	3
4	5	Utilities	Square Feet	203,488	2	513,616		5,804	14,650	4
5	6	Maintenance	Revenue	10,465,138	2	577,398	251,034	3,729,008	205,742	5
6	14	Program Transportation	Revenue	10,465,138	2	53,528	43,011	3,729,008	19,073	6
7	17	Administrative	Revenue	10,465,138	2	97,258	97,258	3,729,008	34,656	7
8	19	Professional Fees	Revenue	10,465,138	2	158,056		3,729,008	56,320	8
9	20	Dues and Subscriptions	Revenue	10,465,138	2	42,747		3,729,008	15,232	9
10	21	Clerical & General Office	Revenue	10,465,138	2	913,495	635,536	3,729,008	325,503	10
11	22	Employee Benefits	Salary	3,609,901	2	1,071,214		1,935,108	574,230	11
12	23	Inservice Training	Revenue	10,465,138	2	12,129		3,729,008	4,322	12
13	24	Travel & Seminar	Revenue	10,465,138	2	10,696		3,729,008	3,811	13
14	26	Insurance	Square Feet	203,488	2	196,315		5,804	5,599	14
15	30	Depreciation	Actual	2,323,968	2	2,323,968		373,144	373,144	15
16	32	Interest	Square Feet	203,488	2	1,999,041		5,804	57,018	16
17	35	Equipment Rental	Revenue	10,465,138	2	32,990		3,729,008	11,755	17
18	4	Laundry	Actual	58,245	1	58,245	44,405	58,245	58,245	18
19	9	Medical Director	Actual	26,091	1	26,091		26,091	26,091	19
20	10	Nursing/Medical Records	Actual	1,195,637	1	1,195,637	1,122,351	1,195,637	1,195,637	20
21	10a	Therapy	Actual	526,444	1	526,444		526,444	526,444	21
22	11	Activities	Actual	90,515	1	90,515	72,156	90,515	90,515	22
23	39	Ancillary	Actual	169,793	1	169,793		169,793	169,793	23
24	42	Provider Participation Fee	Actual	7,690	1	7,690		7,690	7,690	24
25	TOTALS					$ 11,707,979	$ 3,206,348		$ 4,256,646	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 6-30-2010

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	Montgomery Place Assisted Living
Street Address	5550 South Shore Drive
City / State / Zip Code	Chicago, IL 60637
Phone Number	(773) 753-4100
Fax Number	(773) 752-0056

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Carry Forward PG8 Totals				$ 11,707,979	$ 3,206,348		$ 4,256,646	1
2	12	Social Services	Actual	39,305	1	39,305	39,305	39,305	39,305	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,747,284	$ 3,245,653		$ 4,295,951	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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**		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	Revenue Bonds	N/A	11/20/06	$ 40,850,000	$ 34,350,000	05/2038	Variable	$ 1,966,363	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 40,850,000	$ 34,350,000			$ 1,966,363	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 40,850,000	$ 34,350,000			$ 1,966,363	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.)

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description	Amount	Line
1. Real Estate Tax accrual used on 2009 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 2010 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:	Amount	Line
2005		8
2006		9
2007		10
2008		11
2009		12

FOR BHF USE ONLY

Line	Description	Amount	Line
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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Scott E. Martin, CPA

TELEPHONE (574) 236-7637 FAX #: (574) 236-8692

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.	N/A	N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

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? [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).
Montgomery Place Retirement Community, 170,401 Square Feet, 160 Units

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: 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: 07-01-2009 Ending: 06-30-2010

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	40		1992	1992	$ 5,735,741	$	40	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	20,111		20				9
10	Various			1998	19,268		20				10
11	Various			1999	40,652		20				11
12	Various			2000	143,621		20				12
13	Various			2001	117,397		20				13
14	Various			2002	68,258		20				14
15	Various			2003	95,898		20				15
16	Various			2004	76,985		20				16
17	Various			2005	7,058		20				17
18	Various			2006	14,779		20				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

*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

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	Door systems	2007	$ 395	$	20	$	$	$	37
38	Door systems	2007	294		20				38
39	Fan coil motors	2007	178		20				39
40	Water ball valves	2007	7,023		20				40
41	Gas valve	2007	433		20				41
42	Motor, coupling, freeze stat	2007	627		20				42
43	Air flow fan	2007	220		20				43
44	Door gasket for cooler	2007	295		20				44
45	Riser leak repair	2007	233		20				45
46	Repair chiller	2007	1,502		20				46
47	Elevator	2007	877		20				47
48	Elevator	2008	3,481		20				48
49	Building canopy & façade	2009	5,788		20				49
50	General renovations - carpeting	2010	910		20				50
51									51
52									52
53									53
54									54
55									55
56	Total nursing facility depreciation expense			373,144		373,144		2,618,281	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)		$ 6,362,024	$ 373,144		$ 373,144	$	$ 2,618,281	70

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	$ 1,131,796	$	$	$	10	$	71
72	Current Year Purchases	45,159				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,176,955	$	$	$		$	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	1999 Plymouth Voyager	2004	$ 1,382	$	$	$	5	$	76
77	Facility	2005 Glaval Universal Bus	2004	12,922				5		77
78	Facility	Auto	2007	4,110				5		78
79										79
80	TOTALS			$ 18,414	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,448,818	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 373,144	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 373,144	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)	$ 2,618,281	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	Independent Living Alloc	$ 44,171,341	$ 1,950,824	$ 17,396,242	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 44,171,341	$ 1,950,824	$ 17,396,242	91

G. Construction-in-Progress

	Description	Cost	
92		$	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.

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 .

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? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 32,990 Description: Copiers $10,426; Postage Meter $6,188; Various Admin Equipment Rentals $16,376
    (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

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

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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?
   - [ ] YES
   - [X] 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

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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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 Col. 2 & 3	hrs	$	3,861	$ 230,050	$ 852	3,861	$ 230,902	1
2	Licensed Speech and Language Development Therapist	10a Col. 2 & 3	hrs		281	18,874		281	18,874	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a Col. 2 & 3	hrs		3,403	275,839	829	3,403	276,668	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			$	7,545	$ 524,763	$ 1,681	7,545	$ 526,444	14

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06-30-2010 (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	$ 834,069	$	1
2	Cash-Patient Deposits	631,718		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (65,337))	296,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,037		6
7	Other Prepaid Expenses	27,662		7
8	Accounts Receivable (owners or related parties)	365,997		8
9	Other(specify): 30% Reserve on Entrance Fees	11,772,370		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,937,723	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	324,271		12
13	Land	3,301,314		13
14	Buildings, at Historical Cost	44,201,633		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,117,272		16
17	Accumulated Depreciation (book methods)	(20,014,523)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	49,642		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	3,887,764		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,867,373	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 50,805,096	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 613,818	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	422,149		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,072		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	249,873		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	149,834		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,582,746	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	34,350,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Original Bond Premium, net	573,358		43
44	See Supplemental Schedule	19,630,043		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 54,553,401	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 56,136,147	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,331,051)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 50,805,096	$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Assets

Description	Amount
Assets limited as to use - Bond funds	$ 2,731,655
Bond financing costs, net	1,156,109
	$ 3,887,764

Line 36 - Other Short-term Liabilities

Description	Amount
Accrued Medical Director Fee	$ 4,349
Accrued Vacation/Sick/Holiday	145,485
	$ 149,834

Line 44 - Other Long-term Liabilities

Description	Amount
Resident deposits, refundable	$15,027,978
Independent living security deposits	410,324
10% Entrance fees, net	1,214,551
Due to affiliate - Church Home	2,840,326
HC Resident Trust Funds	701
HC Security Deposits	136,163
	$19,630,043

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,284,153)	1
2	Restatements (describe):		2
3	Adjust equity to 6/30/2009 financial statement	630,452	3
4	(Financial Statement was not available for 6/30/09 cost report filing.)		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,653,701)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(720,727)	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)**	$ (720,727)	17
	B. Transfers (Itemize):		
18	Temporarily restricted	43,377	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 43,377	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,331,051)	24 *

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	$ 3,729,008	1
2	Discounts and Allowances for all Levels	(801,385)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,927,623	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	890,331	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 890,331	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	9,517	13
14	Non-Patient Meals	44,973	14
15	Telephone, Television and Radio	89,931	15
16	Rental of Facility Space	164,801	16
17	Sale of Drugs	145,946	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,971	19
20	Radiology and X-Ray	6,125	20
21	Other Medical Services	170,898	21
22	Laundry	10,074	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 659,236	23
	D. Non-Operating Revenue		
24	Contributions	533,175	24
25	Interest and Other Investment Income***	192,110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 725,285	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	6,981,318	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,981,318	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,183,793	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,780,372	31
32	Health Care	1,931,520	32
33	General Administration	2,551,526	33
	B. Capital Expense		
34	Ownership	4,355,999	34
	C. Ancillary Expense		
35	Special Cost Centers	1,277,413	35
36	Provider Participation Fee	7,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,904,520	40
41	**Income before Income Taxes (line 30 minus line 40)****	(720,727)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (720,727)	43

* 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.

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

Description	Amount
Independent Living	$ 6,811,184
Administration Fee Revenue	36,000
Cell Tower Revenue	56,200
Housekeeping Services	4,309
Massage Revenue	4,780
Miscellaneous Income	48,815
Miscellaneous Services	3,546
Transportation	14,251
Various Funds (Employee, Music, Library, etc.)	1,540
Vending	693
	$ 6,981,318

Line 25 Interest and Other Investment Income

Income reported on this line includes changes to the market value of investments and restricted funds. These amounts have not been offset against interest expense reported on Schedule V, line 32.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

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	1,680	1,773	$ 100,865	$ 56.89	1
2	Assistant Director of Nursing	1,824	1,896	65,450	34.52	2
3	Registered Nurses	3,818	3,811	125,522	32.94	3
4	Licensed Practical Nurses	18,659	18,732	444,426	23.73	4
5	CNAs & Orderlies	31,808	31,891	336,179	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	1,949	38,028	19.51	9
10	Activity Assistants	3,793	3,777	33,861	8.97	10
11	Social Service Workers	110	103	10,760	104.47	11
12	Dietician	1,872	1,901	34,855	18.34	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	49,607	50,198	495,966	9.88	15
16	Dishwashers	12,649	12,432	135,472	10.90	16
17	Maintenance Workers	6,930	7,004	137,351	19.61	17
18	Housekeepers	22,316	22,680	262,295	11.57	18
19	Laundry	3,607	3,767	46,719	12.40	19
20	Administrator	1,882	2,029	92,905	45.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,911	1,949	52,130	26.75	23
24	Clerical	20,156	23,168	532,657	22.99	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	1,944	2,019	35,997	17.83	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplement	33,601	34,293	628,463	18.33	33
34	TOTAL (lines 1 - 33)	220,087	225,372	$ 3,609,901 *	$ 16.02	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		$ 7,816	1.3	35
36	Medical Director		26,091	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,638	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		2,340	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,885		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		53

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - LINE 33

		1	2**	3	4
	Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
33 A	Admissions	971	974	$ 29,910	$ 30.71
33 B	Security	7,841	7,875	111,208	14.12
33 C	Transportation	4,082	4,031	43,227	10.59
33 D	Marketing	7,519	7,688	252,437	32.84
33 E	Salaries & Wages - AL	10,324	10,774	142,675	13.24
33 F	Activity Director - IL	2,864	2,951	49,006	16.61
	Total Line 33	33,601	34,293	$ 628,463	$ 18.33

Facility Name & ID Number: Montgomery Place # 0037515 Report Period Beginning: 07-01-2009 Ending: 06-30-2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Von Goeben	Administrator	0	$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Duane & Morris	Legal	$ 9,888
See Legal Supplement	Legal	15,034
Schiff & Hardin LLP	Legal	20,809
Franczek Sullivan	Legal	533
Ungareti & Harris	Legal	3,398
Crowe Horwath LLP	Accounting	87,444
HUB	Service Fee	11,493
ADP	Payroll Processing	20,950
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 169,549

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,849
Unemployment Compensation Insurance	
FICA Taxes	377,345
Employee Health Insurance	563,087
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,919
401K	6,000
Employee Appreciation	11,071
Senior Management Benefits	49,943
Less: ILU Specific Employee Benefits	(55,662)
Less: Marketing Employee Benefits	(59,643)
Less: AL/IL Employee Benefits	(443,489)
TOTAL (agree to Schedule V, line 22, col.8)	$ 512,420

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,795
Health Care Worker Background Check	225
(Indicate # of checks performed)	
Patient Background Checks	
HUB Service Fee	11,493
Drug Tests	195
Licenses/Permits - Admin/Nrsg Adm/Transp	8,747
Dues & subscriptions	18,292
Less: AL/IL Allocated Costs	(28,638)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,109

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,696
Unsupported	(592)
Less: AL/IL Allocated Costs	(6,529)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,575

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

Inv #	Date	GL Acct.	Payee/Vendor	Amount	Comments	Unallowable Cost
1494875	7/20/2009	5446-10-201	Duane Morris LLP	$ 1,564	General - Nursing facility matters	
1501877	8/14/2009	5446-10-201	Duane Morris LLP	1,774	General - Nursing facility matters	
1508918	9/16/2009	5446-10-201	Duane Morris LLP	3,907	General - Nursing facility matters	
1508920	9/16/2009	5446-10-201	Duane Morris LLP	123	Employment matters	
1526030	11/17/2009	5446-10-201	Duane Morris LLP	2,357	General - Nursing facility matters	
1540501	1/22/2010	5446-10-201	Duane Morris LLP	164	Employment matters	
122112	7/31/2009	5446-10-201	Franczek Radelet Attorneys and Counselors	533	Employment matters	
8178126	7/31/2009	5446-10-201	Ungaretti & Harris	1,893	General - Nursing facility matters	
8182390	12/31/2009	5446-10-201	Ungaretti & Harris	370	General - Nursing facility matters	
8183386	1/31/2010	5446-10-201	Ungaretti & Harris	691	General - Nursing facility matters	
8184565	2/28/2010	5446-10-201	Ungaretti & Harris	444	General - Nursing facility matters	
1410169	9/9/2009	5446-10-201	Schiff Hardin LLP	384	General - Nursing facility matters	
1418571	10/9/2010	5446-10-201	Schiff Hardin LLP		Hyde Park Home Care Services	35
1437017	11/30/2009	5446-10-201	Schiff Hardin LLP	594	General - Nursing facility matters	
1443866	1/15/2010	5446-10-201	Schiff Hardin LLP	910	General - Nursing facility matters	
1459761	3/15/2010	5446-10-201	Schiff Hardin LLP	2,679	General NF matters & Hyde Park Home Care	26
1469010	4/15/2010	5446-10-201	Schiff Hardin LLP	285	General - Nursing facility matters	
1479205	5/17/2010	5446-10-201	Schiff Hardin LLP	15,897	General - Nursing facility matters	
		5446-10-201	Unknown		No supporting documentation	15,034
			Total Allowable Legal Expenses	$ 34,567	Total Unreimbursable Legal Expenses	$ 15,095
					Total Legal Expenses	$ 49,662

Facility Name & ID Numl Montgomer # 0037515 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

Date	Payee	Topic	Attendee	Job Class	Location	Fee
7/13/2009	AAHSA	AAHSA CONFERENCE	M. APA	CEO	Washington	658.50
7/15/2009	YMCA	WATER AEROBIC CLASS	M. MASON	DIR. OF ACTIVITIES	Chicago	115.00
9/25/2009	MAYFIELD HEALTHCARE	HEALTHCARE MANAGEMENT	G. MATHIS	DIR. OF ACTIVITIES	Chicago	199.00
10/19/2009	LSN	LSN	M. APA	Management	Chicago	125.00
10/19/2009	LSN	LSN	B. COVINGTON	DON	Chicago	125.00
10/21/2009	NAT'L CONFERENCE ON DEMET	DEMENTIA CLASS	G. MATHIS	DIR. OF ACTIVITIES	Chicago	100.00
11/1/2009	YMCA	FIRST AID CLASS	S.SMITH	DIR. OF ACTIVITIES	Chicago	45.00
11/17/2009	OAKTON	HEALTHCARE MANAGEMENT	R.REIF	PROGRAM DIRECTOR	Chicago	300.00
12/9/2009	YMCA	WATER AEROBIC CLASS	S.SMITH	DIR. OF ACTIVITIES	Chicago	81.35
12/11/2009	YMCA	WATER AEROBIC CLASS	S.SMITH	DIR. OF ACTIVITIES	Chicago	120.00
1/22/2010	ALZHEIMER'S ASSOCIATION	SUPPORT GROUP TRAINING	G. MATHIS	DIR. OF ACTIVITIES	Chicago	60.00
2/1/2010	ZIEGLER	CFO WORKSHOP	S.STEWART	CFO	WEBCAST	295.00
2/11/2010	BECKER	PLANNING & BUDGET	E. AYOT	ACCOUNTING MANAGER	WEBCAST	255.00
2/11/2010	AAHSA	AAHSA CONFERENCE	M. APA	CEO	Washington	690.00
3/16/2010	LSN CONFERENCE	LSN CONFERENCE	MANAGEMENT	Management	Chicago	4,425.00
4/12/2010	SKILL PATH	COMMUNICATION SKILLS	R.REIF	PROGRAM DIRECTOR	Chicago	58.85
4/27/2010	CAREER TRACK	ACCESS WORKSHOP	E. AYOT	ACCOUNTING MANAGER	Chicago	299.00
5/10/2010	SKILL PATH	COMMUNICATION SKILLS	R.REIF	PROGRAM DIRECTOR	Chicago	130.28
6/1/2010	CASP	RHP PROGRAM	M. VONGOBEN	ADMINISTRATOR	ST. LOUIS	1,525.00
6/18/2010	SKILL PATH	COMMUNICATION SKILLS	G. MATHIS	DIR. OF ACTIVITIES	Chicago	72.83
6/21/2010	FRES PRYOR	ACCESS WORKSHOP	R.SANTIGO	ACCOUNTANT	Chicago	299.00
10/29/2010	YMCA	WATER RESCUE CLASS	M. CRAVER	DIR. OF ACTIVITIES	Chicago	45.00
12/11/2009	YMCA	WATER AEROBIC CLASS	S.SMITH	DIR. OF ACTIVITIES	Chicago	80.00
	Unsupported costs					592.19
Total						**10,696.00**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $1,408 (Nursing facility, only)**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 - 20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,369** Line **10.2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **7,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes (Independent Livi** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,446**

(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. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Crowe Horwath LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.