		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0039347

Facility Name: Montgomery Nursing and 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 01/01/2011 to 12/31/2011 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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	335	353	3,707	4,395	8
9	SNF/PED					9
10	ICF	17,848	14,885	224	32,957	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,183	15,238	3,931	37,352	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.03%

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 3,661

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: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	248,226	13,847	6,290	268,363		268,363		268,363			1
2	Food Purchase		228,244		228,244		228,244		228,244			2
3	Housekeeping	125,067	15,915		140,982		140,982		140,982			3
4	Laundry	83,020	15,501		98,521		98,521		98,521			4
5	Heat and Other Utilities			111,576	111,576		111,576		111,576			5
6	Maintenance	52,249	7,296	48,021	107,566		107,566	515	108,081			6
7	Other (specify):* Med Waste Removal			5,496	5,496		5,496		5,496			7
8	TOTAL General Services	508,562	280,803	171,383	960,748		960,748	515	961,263			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,638,508	136,330	56,339	1,831,177	(7,866)	1,823,311		1,823,311			10
10a	Therapy											10a
11	Activities	50,552	6,313	632	57,497		57,497		57,497			11
12	Social Services	39,253	40	632	39,925		39,925		39,925			12
13	CNA Training			2,602	2,602	7,866	10,468		10,468			13
14	Program Transportation		14,219		14,219		14,219		14,219			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,728,313	156,902	69,805	1,955,020		1,955,020		1,955,020			16
	C. General Administration											
17	Administrative	82,833	8,388	332,720	423,941	(3,181)	420,760	(199,844)	220,916			17
18	Directors Fees											18
19	Professional Services			14,914	14,914	3,181	18,095	(1,636)	16,459			19
20	Dues, Fees, Subscriptions & Promotions			53,511	53,511		53,511	(30,201)	23,310			20
21	Clerical & General Office Expenses	61,571	21,271	87,529	170,371		170,371	43,891	214,262			21
22	Employee Benefits & Payroll Taxes			401,301	401,301		401,301	12,067	413,368			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,829	12,829		12,829	640	13,469			24
25	Other Admin. Staff Transportation							1,887	1,887			25
26	Insurance-Prop.Liab.Malpractice			55,706	55,706		55,706	2,009	57,715			26
27	Other (specify):*											27
28	TOTAL General Administration	144,404	29,659	958,510	1,132,573		1,132,573	(171,187)	961,386			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,381,279	467,364	1,199,698	4,048,341		4,048,341	(170,672)	3,877,669			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 and Rehabilitation Center #0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			154,881	154,881		154,881	(2,494)	152,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,367	148,367		148,367	(25,658)	122,709			32
33	Real Estate Taxes			49,547	49,547		49,547		49,547			33
34	Rent-Facility & Grounds							8,490	8,490			34
35	Rent-Equipment & Vehicles			7,361	7,361		7,361	494	7,855			35
36	Other (specify):* Mort. Ins. Premium			11,508	11,508		11,508		11,508			36
37	TOTAL Ownership			371,664	371,664		371,664	(19,168)	352,496			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,798	2,798		2,798		2,798			38
39	Ancillary Service Centers		85,985	546,865	632,850		632,850	(20,915)	611,935			39
40	Barber and Beauty Shops		1,261		1,261		1,261		1,261			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		87,246	609,888	697,134		697,134	(20,915)	676,219			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,381,279	554,610	2,181,250	5,117,139		5,117,139	(210,755)	4,906,384			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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(7,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,971)	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	(2,053)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(790)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,910)	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	(3,609)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,753)		$	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)	(166,002)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (166,002)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (210,755)		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 and Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC dues including lobbying portion	$ (2,685)	20	1
2	Add back 2011 IDPH license paid in 2010	1,990	20	2
3	Eliminate depreciation exp. for non-medicaid assets	(2,494)	30	3
4	Eliminate non-allowable dues	(420)	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**	(3,609)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	515	0	0	0	0	0	0	0	0	0	515	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	515	0	0	0	0	0	0	0	0	0	515	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	66,953	(266,797)	0	0	0	0	0	0	0	0	(199,844)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(790)	3,016	(3,862)	0	0	0	0	0	0	0	0	(1,636)	19
20	Fees, Subscriptions & Promotions	(31,996)	1,795	0	0	0	0	0	0	0	0	0	(30,201)	20
21	Clerical & General Office Expenses	0	43,891	0	0	0	0	0	0	0	0	0	43,891	21
22	Employee Benefits & Payroll Taxes	0	12,067	0	0	0	0	0	0	0	0	0	12,067	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,053)	2,693	0	0	0	0	0	0	0	0	0	640	24
25	Other Admin. Staff Transportation	0	1,887	0	0	0	0	0	0	0	0	0	1,887	25
26	Insurance-Prop.Liab.Malpractice	0	2,009	0	0	0	0	0	0	0	0	0	2,009	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(34,839)	134,311	(270,659)	0	0	0	0	0	0	0	0	(171,187)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,839)	134,826	(270,659)	0	0	0	0	0	0	0	0	(170,672)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(2,494)	0	0	0	0	0	0	0	0	0	0	(2,494)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,420)	77	(18,315)	0	0	0	0	0	0	0	0	(25,658)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,490	0	0	0	0	0	0	0	0	0	8,490	34
35	Rent-Equipment & Vehicles	0	494	0	0	0	0	0	0	0	0	0	494	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,914)	9,061	(18,315)	0	0	0	0	0	0	0	0	(19,168)	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	(20,915)	0	0	0	0	0	0	0	0	(20,915)	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	(20,915)	0	0	0	0	0	0	0	0	(20,915)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,753)	143,887	(309,889)	0	0	0	0	0	0	0	0	(210,755)	45

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	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%	$ 515	$ 515	1
2	V	17	See Schedule VIII		Wellington Management Company	60.00%	66,953	66,953	2
3	V	19	See Schedule VIII		Wellington Management Company	60.00%	3,016	3,016	3
4	V	20	See Schedule VIII		Wellington Management Company	60.00%	1,795	1,795	4
5	V	21	See Schedule VIII		Wellington Management Company	60.00%	43,891	43,891	5
6	V	22	See Schedule VIII		Wellington Management Company	60.00%	12,067	12,067	6
7	V	24	See Schedule VIII		Wellington Management Company	60.00%	2,693	2,693	7
8	V	25	See Schedule VIII		Wellington Management Company	60.00%	1,887	1,887	8
9	V	26	See Schedule VIII		Wellington Management Company	60.00%	2,009	2,009	9
10	V	32	See Schedule VIII		Wellington Management Company	60.00%	77	77	10
11	V	34	See Schedule VIII		Wellington Management Company	60.00%	8,490	8,490	11
12	V	35	See Schedule VIII		Wellington Management Company	60.00%	494	494	12
13	V								13
14	Total			$			$ 143,887	$ * 143,887	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 26,653	Wellington Management Company	60.00%	$ 26,653	$	15
16	V	17	Management Fees	199,632	Wellington Management Company	60.00%		(199,632)	16
17	V	17	Management Fees	133,088	Health Care Financial, LLC	40.00%	65,923	(67,165)	17
18	V	19	Professional Services	3,862	C.J. Schlosser & Company, LLC	40.00%		(3,862)	18
19	V	39	Therapy Services	517,697	NW Rehab, LLC	100.00%	496,782	(20,915)	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	13,411	Wellington Management Company	60.00%	13,411		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			$ 912,658			$ 602,769	$ * (309,889)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ce # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	253,869	7.76	19.40	Salary	$ 61,131	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	$ 61,131		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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	22,211,336	6	$ 2,652	$	4,310,468	$ 515	1
2	17	Administrative	Accumulated Costs	22,211,336	6	345,000	345,000	4,310,468	66,953	2
3	19	Professional Services	Accumulated Costs	22,211,336	6	15,542		4,310,468	3,016	3
4	20	Dues, Fees, Subs, & Promos	Accumulated Costs	22,211,336	6	9,250		4,310,468	1,795	4
5	21	Clerical & General Office Exp.	Accumulated Costs	22,211,336	6	226,167	160,270	4,310,468	43,891	5
6	22	Employee Benefits & PR Taxes	Accumulated Costs	22,211,336	6	62,180		4,310,468	12,067	6
7	24	Travel & Seminar	Accumulated Costs	22,211,336	6	13,877		4,310,468	2,693	7
8	25	Other Admin Staff Transport	Accumulated Costs	22,211,336	6	9,724		4,310,468	1,887	8
9	26	Insurance - Prop, Liab, Malprac	Accumulated Costs	22,211,336	6	10,354		4,310,468	2,009	9
10	32	Interest Expense	Accumulated Costs	22,211,336	6	395		4,310,468	77	10
11	34	Rent - Facility & Ground	Accumulated Costs	22,211,336	6	43,750		4,310,468	8,490	11
12	35	Rent - Equipment & Vehicles	Accumulated Costs	22,211,336	6	2,545		4,310,468	494	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					$ 741,436	$ 505,270		$ 143,887	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 2,286,047	11/30/41	5.6500	$ 128,660	1
2												2
3									Loan Cost Amortization		1,392	3
4									Interest Income		(7,420)	4
5									Home Office Interest		77	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$13,209.94		$ 2,415,500	$ 2,286,047			$ 122,709	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	$ 2,286,047			$ 122,709	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,508 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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 49,547	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,453)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,547	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	40,988	8
	2007	44,524	9
	2008	47,841	10
	2009	50,581	11
	2010	49,547	12

Line 2 : 2010 Taxes Paid

Line 4 : Accrual is based on 2010 taxes paid plus 3% rounded to nearest $1,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing and 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 2010 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 2010.

	(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	$ 49,547.14	$ 49,547.14
2.		Taylor Springs 8-4-716 3/4 S13	$	$
3.		T08 R4	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,547.14	$ 49,547.14

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 683,081	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		5,873	11
12	Doors			1994	2,337	117	20	117		2,025	12
13	Electrical			1994	4,601	230	20	230		3,945	13
14	Exterior Remodeling			1994	4,468		15			4,468	14
15	Interior Remodeling			1994	57,810		15			57,810	15
16	Nurse Call System			1994	1,960		15			1,960	16
17	Plumbing			1994	6,619	331	20	331		5,700	17
18	Windows/Gutters			1994	60,254		15			60,254	18
19	Siding			1994	15,818		15			15,818	19
20	Metal Doors & Frames			1996	953	48	20	48		739	20
21	Metal Carport			1997		113	15	113			21
22	Dining Room Chair Rail			1997	2,230	149	15	149		2,082	22
23	Fire Doors			1997	593	30	20	30		415	23
24	Interior Painting			1997	514		5			514	24
25	Sidewalk Replacement			1997	650	43	15	43		610	25
26	Beauty Shop Remodeling			1998	4,287	214	20	214		2,840	26
27	Shower Room Remodeling			1998	1,199	60	20	60		799	27
28	Shelving			1998	566	28	20	28		379	28
29	Water Heater			1998	6,040	403	15	403		5,335	29
30	Shelving			1998	208		10			208	30
31	Wall Mounted Laundry Tub			1998	181	9	20	9		126	31
32	Air Conditioning Unit			2000	557		10			557	32
33	Fire Doors			2001	1,535	102	15	102		1,083	33
34	Cove Base			2001		44	10	44			34
35	Air Conditioning Unit			2001	1,696	85	10	85		1,696	35
36	Cove Base			2002		111	10	111			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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioning Unit	2002	$ 1,446	$ 20	10	$ 20	$	$ 1,559	37
38	Flooring & Cove Base	2002		177	10	177			38
39	Wall Guard	2002	1,927	128	15	128		1,263	39
40	Fire Doors	2002	1,042	69	15	69		660	40
41	AC/Heat Pumps	2002	1,580	158	10	158		1,488	41
42	Air Conditioning Unit	2003	3,110	311	10	311		2,606	42
43	11 Fire Doors	2003	5,950	397	15	397		3,272	43
44	Closet Doors - Resident Rooms	2004	3,628	242	15	242		1,816	44
45	Wiring Outside Lights	2004	1,145	57	20	57		453	45
46	Tile	2004	878	88	10	88		695	46
47	Commercial Water Heater	2004	7,664	766	10	766		5,748	47
48	Floor Tile	2004	1,186	119	10	119		840	48
49	66 Gallon Hot Water Heater	2004	931	93	10	93		659	49
50	Patio and Sidewalks	2004	14,316	954	15	954		6,999	50
51	Concrete Dumpster Pad/Fencing	2004	1,520	101	15	101		760	51
52	Range Hood	2005	832	42	20	42		291	52
53	Closet Doors - Resident Rooms	2005	3,689	369	10	369		2,499	53
54	Outside Light Fixtures	2005	2,025	203	10	203		1,360	54
55	Air Conditioning Unit	2005	7,610	761	10	761		4,917	55
56	Electrical Work	2005	5,528	276	20	276		1,797	56
57	Tile and Cove Base	2005	2,064	206	10	206		1,325	57
58	Heating/Cooling Unit	2005	558		5			558	58
59	Wallpaper	2005	811		5			811	59
60	Therapy Room Cabinets	2005	1,200	80	15	80		480	60
61	New Roof - 200 & 500 Wings	2005	74,745	4,983	15	4,983		31,144	61
62	Wall Guard	2006	570	38	15	38		222	62
63	6 Oak Doors	2006	3,469	231	15	231		1,291	63
64	Smoke Detectors	2006	683	68	10	68		387	64
65	Exhaust Fans for Kitchen	2006	1,034	103	10	103		543	65
66	New Roof - 300 Wing	2007	30,200	3,020	10	3,020		14,597	66
67	Shower & Wall Remodel	2007	5,510	276	20	276		1,355	67
68	Water Heaters	2006	1,695	170	10	170		941	68
69	Air Conditioning Unit	2006	3,414	361	5-10	361		2,958	69
70	TOTAL (lines 4 thru 69)		$ 1,415,318	$ 55,807		$ 55,807	$	$ 1,033,998	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,415,318	$ 55,807		$ 55,807	$	$ 1,033,998	1
2	Storage Shed	2006	1,583	158	10	158		877	2
3	Fire Doors	2006	4,939	329	15	329		1,701	3
4	Patio & Sidewalks	2006	9,566	638	15	638		3,512	4
5	Exhaust Fan Replacement	2007	3,862	386	10	386		1,609	5
6	Interior Remodeling - Shower Room	2007	20,896	1,045	20	1,045		4,471	6
7	Water Heaters	2007	10,972	1,097	10	1,097		5,214	7
8	Doors - Metal	2007	4,450	223	20	223		1,032	8
9	Air Conditioning Units	2007	3,512	702	5	702		3,079	9
10	Flooring	2007	10,399	1,040	10	1,040		4,414	10
11	Landscaping - Sign Area	2007	2,575	258	10	258		1,180	11
12	Repaved Driveway	2007	4,750	594	8	594		2,622	12
13	Flooring	2008	132,076	13,208	10	13,208		47,100	13
14	Wallpapering	2008	45,923	9,185	5	9,185		33,204	14
15	Electrical Work	2008	11,765	588	20	588		2,101	15
16	5 A/C Units & Installation	2008	8,021	802	10	802		2,875	16
17	Facility Signage	2008	8,602	1,720	5	1,720		5,945	17
18	8 Oak Doors	2008	4,659	311	15	311		1,035	18
19	In Wall Fountain - Labor & Materials	2008	5,321	760	7	760		2,660	19
20	Handrails & Hardware	2008	8,950	597	15	597		2,237	20
21	Cabinets, Countertops, & Sinks	2008	28,200	1,880	15	1,880		7,050	21
22	5 Shaped Cornices	2008	3,034	303	10	303		1,011	22
23	Cabinet Installation	2008	3,320	221	15	221		701	23
24	3 A/C Units	2009	1,839	368	5	368		919	24
25	Sinks/Faucets - Resident Rooms	2009	2,985	149	20	149		333	25
26	Generator	2009	50,432	2,522	20	2,522		7,145	26
27	Rood Replacement - 100 & 400 Halls	2009	36,200	3,620	10	3,620		9,653	27
28	10 Upholstered Cornices	2009	5,255	526	10	526		1,489	28
29	Wi-Fi Access Installation	2009	1,892	95	20	95		237	29
30	130 Gallon Water Heater	2009	12,706	1,271	10	1,271		3,177	30
31	Ceiling Tiles - Therapy Room	2009	676	68	10	68		158	31
32	Plexiglass for Maint. Shed	2009	758	76	10	76		164	32
33	Closet Doors	2009	548	55	10	55		119	33
34	TOTAL (lines 1 thru 33)		$ 1,865,984	$ 100,602		$ 100,602	$	$ 1,193,022	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,865,984	$ 100,602		$ 100,602	$	$ 1,193,022	1
2	New Entry Door	2010	3,000	300	10	300		475	2
3	4 A/C/Heat Units	2010	2,618	523	5	523		695	3
4	New 400 Amp Breaker	2010	1,787	119	15	119		169	4
5	Flooring	2010	5,340	534	10	534		572	5
6	Insulate Duct Work	2010	14,800	987	15	987		987	6
7	Kitchen Flooring	2011	4,520	414	10	414		414	7
8	Breaker Panel & Installation	2011	10,994	458	20	458		458	8
9	Sprinkler System	2011	117,500	3,133	25	3,133		3,133	9
10	6 A/C/Heat Units	2011	4,502	472	5	472		472	10
11	Motion Sensor/Detectors	2011	1,094	109	5	109		109	11
12	Water Heater	2011	1,145	29	10	29		29	12
13	Sidewalks	2011	3,850	114	15	114		114	13
14	Vinyl Fence and Gate	2011	5,325	222	10	222		222	14
15	Asphalt/Seal/Stripe/Patch & Repair Parking Lot	2011	28,870	921	8	921		921	15
16	Drainage Downspouts Installation	2011	2,880	48	10	48		48	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)		$ 2,074,209	$ 108,985		$ 108,985	$	$ 1,201,840	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 379,251	$ 33,366	$ 33,366	$	5-20 yrs	$ 148,667	71
72	Current Year Purchases	137,774	7,187	7,187		5-20 yrs	7,187	72
73	Fully Depreciated Assets	314,023	2,630	2,630		5-10 yrs	314,023	73
74								74
75	TOTALS	$ 831,048	$ 43,183	$ 43,183	$		$ 469,877	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2004 Ford Wheelchair Van	2004	$ 35,799	$	$	$	4	$ 35,799	76
77	Facility Use	2002 Dodge 3500 Ram Wheelchai	2011	5,266	219	219		4	219	77
78										78
79										79
80	TOTALS			$ 41,065	$ 219	$ 219	$		$ 36,018	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)	$ 2,973,995	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,387	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,387	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,707,735	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 7,855 Description: Postage Machine $756; Copier $6,605; Home Office Vehicle Lease $494
(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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		702		702
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		7,866		7,866
6	Transportation				
7	Contractual Payments		520		520
8	CNA Competency Tests		1,380		1,380
9	TOTALS	$	$ 10,468	$	$ 10,468
10	SUM OF line 9, col. 1 and 2 (e)	$ 10,468			

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	25
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	25

(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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				80,959		80,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached Schedule				13,227	525,950	5,026	13,227	530,976	12
13	Other (specify):									13
14	TOTAL			$	13,227	$ 525,950	$ 85,985	13,227	$ 611,935	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ 32,291	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,041,575		3
4	Supply Inventory (priced at)	14,703		4
5	Short-Term Investments			5
6	Prepaid Insurance	34,259		6
7	Other Prepaid Expenses	1,610		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,124,438	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,200		12
13	Land	105,347		13
14	Buildings, at Historical Cost	2,038,369		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	853,800		16
17	Accumulated Depreciation (book methods)	(1,716,929)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	87,152		21
22	Other Long-Term Assets (spe**Loan Costs**	41,630		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,429,569	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,554,007	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 748,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,983		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,888		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	67,525		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,075,302	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	332,793		39
40	Mortgage Payable	2,327,341		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)**	$ 2,660,134	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,735,436	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,181,429)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,554,007	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,423,049)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,423,049)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	406,982	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	(165,362)	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)**	$ 241,620	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)**	$ (1,181,429)	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 4,773,718	1
2	Discounts and Allowances for all Levels	(79,780)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,693,938	3
	B. Ancillary Revenue		
4	Day Care	250	4
5	Other Care for Outpatients		5
6	Therapy	803,355	6
7	Oxygen	2,892	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 806,497	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8,422	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	4,537	19
20	Radiology and X-Ray	3,307	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,266	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,420	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,420	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,524,121	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	960,748	31
32	Health Care	1,955,020	32
33	General Administration	1,132,573	33
	B. Capital Expense		
34	Ownership	371,664	34
	C. Ancillary Expense		
35	Special Cost Centers	636,909	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)***	$ 5,117,139	40
41	**Income before Income Taxes (line 30 minus line 40)****	406,982	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 406,982	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 and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,646	1,835	$ 50,511	$ 27.53	1
2	Assistant Director of Nursing	1,926	2,203	52,561	23.86	2
3	Registered Nurses	5,937	6,414	138,136	21.54	3
4	Licensed Practical Nurses	23,426	24,826	412,002	16.60	4
5	CNAs & Orderlies	94,555	100,715	963,299	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,299	5,600	50,552	9.03	10
11	Social Service Workers	1,900	2,102	39,253	18.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,857	25,596	248,226	9.70	15
16	Dishwashers					16
17	Maintenance Workers	3,030	3,341	52,249	15.64	17
18	Housekeepers	12,500	13,324	125,067	9.39	18
19	Laundry	9,449	9,882	83,020	8.40	19
20	Administrator	1,810	2,080	82,833	39.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,069	3,412	61,571	18.05	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	1,978	2,165	21,999	10.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	190,382	203,495	$ 2,381,279 *	$ 11.70	34

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	109	$ 6,290	1,3	35
36	Medical Director	Contract	9,600	9,3	36
37	Medical Records Consultant	16	1,160	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	4,992	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	8	632	11,3	44
45	Social Service Consultant	8	632	12,3	45
46	Other(specify) Compliance Consultir	210	10,123	10,3	46
47	Quality Assurance Nurse	N/A	26,653	10,3	47
48	Clerical	N/A	13,411	21,3	48
49	TOTAL (lines 35 - 48)	351	$ 73,493		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carla Vonder Haar	Administrator		$ 82,833
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,833

B. Administrative - Other

Description	Amount
Wellington Management Co. - Management Fees	$ 199,632
Health Care Financial, LLC - Management Fees	133,088
TOTAL (agree to Schedule V, line 17, col. 3)	$ 332,720
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Co., LLC	Accounting Services	$ 3,862
May, Cocagne, & King	Audit Fees	8,396
Sandberg Phoenix & von Gontard P.	Legal Services	1,866
Burnside, Johnston, Sheafor & Kelly	Collection Fees (eliminated)	790
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 14,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,463
Unemployment Compensation Insurance	52,949
FICA Taxes	180,160
Employee Health Insurance	54,137
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	28,674
Employee Dental/Vision Insurance	926
Home Office Employee Benefits	12,067
Employee Deductible Reimb. Expense	2,500
Employee Life/Disability Insurance	492
TOTAL (agree to Schedule V, line 22, col.8)	$ 413,368

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	$ 1,990
Advertising: Employee Recruitment	7,720
Health Care Worker Background Check	
(Indicate # of checks performed 1)	11
Patient Background Checks 78	1,260
Dues, Subscriptions, & Manuals	4,069
Licenses & Fees	505
Bank Service Charges	2,045
IHCA Dues	3,915
Home Office Dues, Fees, Subscriptions	1,795
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,310

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,317
Seminar Expense	3,459
Home Office Travel & Seminar	2,693
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,469

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $3,915**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **13,711** 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 fo
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 Departmen
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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? **58.84%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
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 ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of service
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
12/31/2011

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(3,181)
PROFESSIONAL SERVICES	19	3,181
To reclass various expenses to proper lines		
NURSE AIDE TRAINING	13	7,866
NURSING & MEDICAL RECORDS	10	(7,866)
To reclass CNA trainer wages		

Montgomery Nursing and Rehabilitation Center
Attachment to Sch. XVII
December 31, 2011

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	$ 406,982
CONVERSION TO CASH BASIS ADJUSTMENTS	(523,494)
SUBTOTAL	(116,512)
DEPRECIATION ADJUSTMENT	(97,631)
LOSS ON DISPOSAL OF FIXED ASSETS ADJUSTMENT	(36,140)
MISC. NON-DEDUCTIBLE EXPENSE	22,313
TAX NET INCOME (LOSS), PER FEDERAL RETURN	$ (227,970)

MONTGOMERY NURSING & REHAB CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2011

Seminar Participant	Job Title	Dates	City	Title of Seminar	Sponsor	Cost	Seminar Lodging Travel/Meals
Holly Jensen	Billing	12/15/2011	Fenton, MO	Advance to ICD-10-CM-Learn the Basics to be Ready	Cross Country Education	120	9
Sarah Laurent, Dana Waugh	C.N.A. Instructor, MDS Coordinator	4/15/2011	Springfield, IL	Annual C.N.A. Instructor Conference	Capital City Training Center	180	
						300	9

Total Seminar Lodging/Travel/Meals	9
Online CPE Service for Nurses	3,150
Other Travel Expenses <$250	7,317
Home Office Travel & Seminar	2,693
Total Travel & Seminar, Line 24	13,469

Montgomery Nursing & Rehabilitation Center

Attachment to Schedule XIV

12/31/2011

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5 +6)
Line #	Service	Schuler V Line & Column Reference	Units of Service	Cost	Units of Service	Cost	Cost		
12	Other:								
	Licensed Occupational Ther	39,8			5,529	202,963		5,529	202,963
	Licensed Speech Therapist	39,8			2,438	185,767		2,438	185,767
	Licensed Physical Therapist	39,8			5,260	108,052	5,026	5,260	113,078
	X-Ray	39,3				10,885			10,885
	Laboratory	39,3				7,097			7,097
	Specialty Mattresses/Overla	39,3				11,186			11,186
	Total to Schedule XIV, Line 12		-	-	13,227	525,950	5,026	13,227	530,976