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.

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

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	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501[C][3]		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Fred Saviano, CFO **Telephone Number:** (773) 753-4100
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 07/01/2010 to 06/30/2011 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) Mary Von Goeben
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Scott E. Martin, CPA, Director
(Firm Name & Address) Crowe Horwath LLP, 330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624-000
(Telephone) (574) 232-3992 Fax # (574) 236-8692

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: 07/01/2010 Ending: 06/30/2011

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 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	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,549	6,982	4,812	13,343	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,549	6,982	4,812	13,343	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.39%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [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 01/28/1992

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 4,410

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: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	690,441	106,503	12,347	809,291		809,291	(477,479)	331,812			1
2	Food Purchase		500,012		500,012		500,012	(314,144)	185,868			2
3	Housekeeping	232,515	58,719	49,767	341,001		341,001	(332,183)	8,818			3
4	Laundry	49,416	13,910	1,517	64,843		64,843		64,843			4
5	Heat and Other Utilities			456,122	456,122		456,122	(443,112)	13,010			5
6	Maintenance	276,402	10,854	306,503	593,759		593,759	(378,807)	214,952			6
7	Other (specify):*											7
8	TOTAL General Services	1,248,774	689,998	826,256	2,765,028		2,765,028	(1,945,725)	819,303			8
	B. Health Care and Programs											
9	Medical Director			26,091	26,091		26,091		26,091			9
10	Nursing and Medical Records	1,142,791	52,487	18,989	1,214,267		1,214,267	(224)	1,214,043			10
10a	Therapy		3,095	610,386	613,481		613,481		613,481			10a
11	Activities	74,122	303	22,528	96,953		96,953		96,953			11
12	Social Services	66,015			66,015		66,015		66,015			12
13	CNA Training											13
14	Program Transportation	44,030		12,753	56,783		56,783	(41,099)	15,684			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,326,958	55,885	690,747	2,073,590		2,073,590	(41,323)	2,032,267			16
	C. General Administration											
17	Administrative					135,359	135,359	(85,336)	50,023			17
18	Directors Fees											18
19	Professional Services			170,132	170,132		170,132	(109,389)	60,743			19
20	Dues, Fees, Subscriptions & Promotions			39,785	39,785		39,785	(26,451)	13,334			20
21	Clerical & General Office Expenses	723,175	19,785	173,918	916,878	(135,359)	781,519	(533,198)	248,321			21
22	Employee Benefits & Payroll Taxes			1,245,246	1,245,246		1,245,246	(650,485)	594,761			22
23	Inservice Training & Education			17,022	17,022		17,022	(10,731)	6,291			23
24	Travel and Seminar			12,541	12,541		12,541	(7,906)	4,635			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			179,990	179,990		179,990	(174,856)	5,134			26
27	Other (specify):* Unallowable Costs			7,136	7,136		7,136	(7,136)				27
28	TOTAL General Administration	723,175	19,785	1,845,770	2,588,730		2,588,730	(1,605,488)	983,242			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,298,907	765,668	3,362,773	7,427,348		7,427,348	(3,592,536)	3,834,812			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.

Facility Name & ID Number Montgomery Place #0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			2,399,088	2,399,088		2,399,088	(2,017,873)	381,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,988,665	1,988,665		1,988,665	(1,933,054)	55,611			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,787	38,787		38,787	(24,453)	14,334			35
36	Other (specify):*											36
37	TOTAL Ownership			4,426,540	4,426,540		4,426,540	(3,975,380)	451,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,429	43,367	212,796		212,796		212,796			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,380	16,380		16,380		16,380			42
43	Other (specify):* AL/IL & Marketin	402,427	111,829	597,482	1,111,738		1,111,738	(1,111,738)				43
44	TOTAL Special Cost Centers	402,427	281,258	657,229	1,340,914		1,340,914	(1,111,738)	229,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,701,334	1,046,926	8,446,542	13,194,802		13,194,802	(8,679,654)	4,515,148			45

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

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

SCHEDULE V - Reclassifications

		To Line	From Line
Administrator wages	$ 135,359	17	21

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	(45,862)	2		4
5	Telephone, TV & Radio in Resident Rooms	(60,390)	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	(13,243)	32		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	(36,000)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,295)	27		24
25	Fund Raising, Advertising and Promotional	(858,969)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(7,642,895)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,679,654)		$	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))**	$ (8,679,654)		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

Montgomery Place

ID# 0037515

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL Dietary Costs	$ (477,479)	1	1
2	AL/IL Food Purchases	(267,465)	2	2
3	Revenue Offset - Vending	(817)	2	3
4	Revenue Offset - Housekeeping	(11,456)	3	4
5	Revenue Offset - Guest Apartment	(20,398)	3	5
6	AL/IL Housekeeping	(300,329)	3	6
7	AL/IL Heat & other utilities	(443,112)	5	7
8	Revenue Offset - Miscellaneous Services	(12,115)	6	8
9	AL/IL Maintenance	(366,692)	6	9
10	Revenue Offset - Med Records	(224)	10	10
11	AL/IL Transportation	(26,757)	14	11
12	Revenue Offset - Transportation	(14,342)	14	12
13	AL/IL Administrator	(85,336)	17	13
14	AL/IL Professional Svc	(103,622)	19	14
15	Unallowable Legal Expenses	(5,767)	19	15
16	AL/IL Specific Dues, Fees, Subs	(489)	20	16
17	Unallowable Lobby Expenses	(1,549)	20	17
18	AL/IL Life Services Network Membership Dues	(1,665)	20	18
19	AL/IL Allocated Dues, Fees, Subs	(22,748)	20	19
20	AL/IL Office & Clerical	(423,619)	21	20
21	Revenue Offset - WIFI Income to the extent of expenses	(10,700)	21	21
22	Music Fund Expenses	(259)	21	22
23	Library Fund Expenses	(2,230)	21	23
24	AL/IL & Marketing Employee Benefits	(145,932)	22	24
25	AL/IL Allocated Admin & Other Employee Benefits	(504,553)	22	25
26	AL/IL Inservice	(10,731)	23	26
27	AL/IL Travel & Seminar	(7,906)	24	27
28	AL/IL Insurance	(174,856)	26	28
29	Late Fees/Service chgs	(738)	27	29
30	Prior Year Items	15,897	27	30
31	AL/IL Equip depn	(2,017,873)	30	31
32	Unallowable Investment Fees	(25,688)	32	32
33	Unallowable Security Deposit Interest Expense	(12)	32	33
34	AL/IL Interest	(1,894,111)	32	34
35	AL/IL Equip rental	(24,453)	35	35
36	AL/IL Wages	(197,483)	43	36
37	AL/IL Specific Expenses	(55,286)	43	37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,642,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(477,479)	0	0	0	0	0	0	0	0	0	0	(477,479)	1
2	Food Purchase	(314,144)	0	0	0	0	0	0	0	0	0	0	(314,144)	2
3	Housekeeping	(332,183)	0	0	0	0	0	0	0	0	0	0	(332,183)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(443,112)	0	0	0	0	0	0	0	0	0	0	(443,112)	5
6	Maintenance	(378,807)	0	0	0	0	0	0	0	0	0	0	(378,807)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,945,725)	0	0	0	0	0	0	0	0	0	0	(1,945,725)	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	(224)	0	0	0	0	0	0	0	0	0	0	(224)	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	(41,099)	0	0	0	0	0	0	0	0	0	0	(41,099)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(41,323)	0	0	0	0	0	0	0	0	0	0	(41,323)	16
	C. General Administration													
17	Administrative	(85,336)	0	0	0	0	0	0	0	0	0	0	(85,336)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(109,389)	0	0	0	0	0	0	0	0	0	0	(109,389)	19
20	Fees, Subscriptions & Promotions	(26,451)	0	0	0	0	0	0	0	0	0	0	(26,451)	20
21	Clerical & General Office Expenses	(533,198)	0	0	0	0	0	0	0	0	0	0	(533,198)	21
22	Employee Benefits & Payroll Taxes	(650,485)	0	0	0	0	0	0	0	0	0	0	(650,485)	22
23	Inservice Training & Education	(10,731)	0	0	0	0	0	0	0	0	0	0	(10,731)	23
24	Travel and Seminar	(7,906)	0	0	0	0	0	0	0	0	0	0	(7,906)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(174,856)	0	0	0	0	0	0	0	0	0	0	(174,856)	26
27	Other (specify):*	(7,136)	0	0	0	0	0	0	0	0	0	0	(7,136)	27
28	**TOTAL General Administration**	(1,605,488)	0	0	0	0	0	0	0	0	0	0	(1,605,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,592,536)	0	0	0	0	0	0	0	0	0	0	(3,592,536)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Montgomery Place** **#** **0037515** **Report Period Beginning:** **07/01/2010** **Ending:** **06/30/2011**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(2,017,873)	0	0	0	0	0	0	0	0	0	0	(2,017,873)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,933,054)	0	0	0	0	0	0	0	0	0	0	(1,933,054)	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	(24,453)	0	0	0	0	0	0	0	0	0	0	(24,453)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,975,380)	0	0	0	0	0	0	0	0	0	0	(3,975,380)	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):*	(1,111,738)	0	0	0	0	0	0	0	0	0	0	(1,111,738)	43
44	**TOTAL Special Cost Centers**	(1,111,738)	0	0	0	0	0	0	0	0	0	0	(1,111,738)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,679,654)	0	0	0	0	0	0	0	0	0	0	(8,679,654)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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
N/A	N/A	N/A	N/A	Hyde Park Home Care	Hyde Park	Home Health Agency

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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 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		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: 07/01/2010 Ending: 06/30/2011

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	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: 07/01/2010 Ending: 6/30/2011

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 [ ] NO [x]

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

Name of Related Organization: Montgomery Place Assisted & Independent Livin
Street Address: 5550 Shouth 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	$ 809,291	$ 690,441	40,464	$ 289,273	1
2	2	Food	Meals	113,205	2	453,333		40,464	162,039	2
3	3	Housekeeping	Square Feet	203,488	2	309,147	232,515	5,804	8,818	3
4	5	Utilities	Square Feet	203,488	2	456,122		5,804	13,010	4
5	6	Maintenance	Revenue	11,240,540	2	581,644	276,402	4,154,039	214,952	5
6	14	Program Transportation	Revenue	11,240,540	2	42,441	42,441	4,154,039	15,684	6
7	17	Administrative	Revenue	11,240,540	2	135,359	135,359	4,154,039	50,023	7
8	19	Professional Fees	Revenue	11,240,540	2	164,365		4,154,039	60,743	8
9	20	Dues and Subscriptions	Revenue	11,240,540	2	36,082		4,154,039	13,334	9
10	21	Clerical & General Office	Revenue	11,240,540	2	671,940	671,940	4,154,039	248,321	10
11	22	Employee Benefits	Salary	3,701,334	2	1,099,314		2,002,530	594,761	11
12	23	Inservice Training	Revenue	11,240,540	2	17,022		4,154,039	6,291	12
13	24	Travel & Seminar	Revenue	11,240,540	2	12,541		4,154,039	4,635	13
14	26	Insurance	Square Feet	203,488	2	179,990		5,804	5,134	14
15	30	Depreciation	Actual	2,399,088	2	2,399,088		381,215	381,215	15
16	32	Interest	Square Feet	203,488	2	1,949,722		5,804	55,611	16
17	35	Equipment Rental	Revenue	11,240,540	2	38,787		4,154,039	14,334	17
18	4	Laundry	Actual	64,843	1	64,843	49,416	64,843	64,843	18
19	9	Medical Director	Actual	26,091	1	26,091		26,091	26,091	19
20	10	Nursing/Medical Records	Actual	1,214,043	1	1,214,043	1,214,043	1,214,043	1,214,043	20
21	10A	Therapy	Actual	613,481	1	613,481		613,481	613,481	21
22	11	Activities	Actual	96,953	1	96,953	74,122	96,953	96,953	22
23	12	Social Services	Actual	66,015	1	66,015	66,015	66,015	66,015	23
24	39	Ancillary	Actual	212,796	1	212,796		212,796	212,796	24
25	TOTALS					$ 11,650,410	$ 3,452,694		$ 4,432,400	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 [ ] NO [x]

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

Name of Related Organization: Montgomery Place Assisted & Independent Livin
Street Address: 5550 Shouth 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				$ 11,650,410	$ 3,452,694		$ 4,432,400	1
2	42	Provider Participation Fee	Actual	16,380	1	16,380		16,380	16,380	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					$ 11,666,790	$ 3,452,694		$ 4,448,780	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Illinois Finance Authority		X	Facility (revenue bonds)	N/A	11/20/06	$ 40,850,000	$ 33,840,000	05/2038	Variable	$ 1,962,965	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 40,850,000	$ 33,840,000			$ 1,962,965	9
	B. Non-Facility Related*											
10	Remove AL/IL portion of interest expense										(1,894,111)	10
11	Interest income offset										(13,243)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,907,354)	14
15	TOTALS (line 9+line14)						$ 40,850,000	$ 33,840,000			$ 55,611	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:** 07/01/2010 **Ending:** 06/30/2011

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.**	$	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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Fred Saviano, CFO

TELEPHONE (773) 753-4100 FAX #: (773) 752-0056

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.	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 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 Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 Assisted Living, 14,833 Square Feet, 22 Units

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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 Use	2 Square Feet	3 Year Acquired	4 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: 07/01/2010 Ending: 06/30/2011

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	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	Various			2007	12,137		20				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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Elevator	2008	$ 3,481	$	20	$	$	$	37
38	Building canopy & façade	2009	5,788		20				38
39	General renovations - carpeting	2010	910		20				39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56	Total nursing facility depreciation expense			381,215		381,215		2,999,496	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)		$ 6,362,084	$ 381,215		$ 381,215	$	$ 2,999,496	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: 07/01/2010 Ending: 06/30/2011

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	$ 1,176,955	$	$	$	10	$	71
72	Current Year Purchases	41,580				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,218,535	$	$	$		$	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	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)	$ 8,490,458	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 381,215	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 381,215	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)	$ 2,999,496	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Assisted & Independent Living Alloc	$ 44,949,061	$ 2,017,873	$ 19,414,114	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 44,949,061	$ 2,017,873	$ 19,414,114	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 195,862	92
93			93
94			94
95		$ 195,862	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.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 38,787 Description: Copiers $32,748; Postage Machine $6,039
    (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			$	$	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: 07/01/2010 Ending: 06/30/2011

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?
   - [ ] 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.

Facility Name & ID Number Montgomery Place

STATE OF ILLINOIS
0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$	5,952	$ 260,614	$ 1,114	5,952	$ 261,728	1
2	Licensed Speech and Language Development Therapist		hrs		58	3,806		58	3,806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		9,394	345,966	1,981	9,394	347,947	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			$	15,404	$ 610,386	$ 3,095	15,404	$ 613,481	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:** 07/01/2010 **Ending:** 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2011 **(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	$ 2,462,476	$	1
2	Cash-Patient Deposits	700,099		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	268,758		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	80,323		7
8	Accounts Receivable (owners or related parties)	182,881		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,694,537	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,470,300		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	45,015,059		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,170,848		16
17	Accumulated Depreciation (book methods)	(22,413,610)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	195,862		22
23	Other(specify): See Supplemental Schedule	9,023,459		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,715,530	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 51,410,067	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,735	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,006,683		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	557,336		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,814,754	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	33,840,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Original Bond Premium, net	536,184		43
44	See Supplemental Schedule	21,157,605		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 55,533,789	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 57,348,543	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,938,476)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 51,410,067	$	48

***(See instructions.)**

Facility Name & ID Number **Montgomery Place** **# 0037515** **Report Period Beginning:** **7/1/2010** **Ending:** **6/30/2011**

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Assets

Description	Amount
Assets limited as to use - Bond funds	$ 7,891,991
Bond financing costs, net	1,080,977
Assets limited as to use - donor restricted	50,491
	$ 9,023,459

Line 44 - Other Long-term Liabilities

Description	Amount
Due to affiliate - Church Home	$ 2,822,326
Refundable entrance fees, net of amortization	17,012,154
Nonrefundable entrance fees, net of amortization	1,323,125
	$21,157,605

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,331,051)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,331,051)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(605,785)	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)**	$ (605,785)	17	
	B. Transfers (Itemize):			
18	**Change in Temporarily Restricted Net Assets**	(1,640)	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,640)	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,938,476)	24	*

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 4,154,039	1
2	Discounts and Allowances for all Levels	(1,038,895)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,115,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	954,399	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 954,399	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	9,720	13
14	Non-Patient Meals	45,862	14
15	Telephone, Television and Radio	89,535	15
16	Rental of Facility Space	20,398	16
17	Sale of Drugs	161,108	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,409	19
20	Radiology and X-Ray	7,600	20
21	Other Medical Services	170,117	21
22	Laundry	9,593	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 538,342	23
	D. Non-Operating Revenue		
24	Contributions	975	24
25	Interest and Other Investment Income***	486,073	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 487,048	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,494,084	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,494,084	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,589,017	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,765,028	31
32	Health Care	2,073,590	32
33	General Administration	2,588,730	33
	B. Capital Expense		
34	Ownership	4,426,540	34
	C. Ancillary Expense		
35	Special Cost Centers	1,324,534	35
36	Provider Participation Fee	16,380	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,194,802	40
41	**Income before Income Taxes (line 30 minus line 40)****	(605,785)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (605,785)	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.**

Facility Name & ID Number **Montgomery Place** **#** **0037515** **Report Period Beginning:** **7/1/2010** **Ending:** **6/30/2011**

SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule

Line 25 Interest and Other Investment Income

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

Line 28 - Other Revenue

Description		Amount
Independent Living, including amortized entrance fees	$	7,086,501
Non-resident garage		91,489
Housekeeping Services		11,456
Miscellaneous Services		12,115
Care Assurance Fund/Music Fund/Library Fund/Resident Funds		3,135
Cell Tower Revenue		41,089
WIFI Revenue		15,135
Transportation		14,342
Vending		817
Massage Revenue		4,515
Miscellaneous Income		38,888
Insurance Proceeds (FY 2010 Flood Damage)		138,378
Medical Records		224
CH Admin Fee & Fee Revenue from HPHCS [1]		36,000
	$	7,494,084

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	1,720	1,930	$ 102,937	$ 53.34	1
2	Assistant Director of Nursing	1,632	1,632	49,768	30.50	2
3	Registered Nurses	5,972	6,580	218,432	33.20	3
4	Licensed Practical Nurses	15,511	16,821	410,208	24.39	4
5	CNAs & Orderlies	30,473	33,337	324,137	9.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,928	2,096	39,664	18.92	9
10	Activity Assistants	3,817	4,186	34,458	8.23	10
11	Social Service Workers	1,757	1,855	66,015	35.59	11
12	Dietician	1,984	2,061	38,631	18.74	12
13	Food Service Supervisor	2,045	2,144	65,718	30.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	47,915	51,365	491,893	9.58	15
16	Dishwashers	9,882	10,614	94,199	8.87	16
17	Maintenance Workers	7,650	8,279	158,679	19.17	17
18	Housekeepers	21,873	23,930	232,515	9.72	18
19	Laundry	4,500	4,905	49,416	10.07	19
20	Administrator	1,792	2,210	135,359	61.25	20
21	Assistant Administrator					21
22	Other Administrative	6,808	8,417	451,933	53.69	22
23	Office Manager	1,900	2,080	69,178	33.26	23
24	Clerical	3,463	3,854	66,705	17.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,005	2,306	37,309	16.18	31
32	Other Health C: See Supplement	29,871	32,228	359,236	11.15	32
33	Other(specify) Marketing	5,708	6,352	204,944	32.26	33
34	TOTAL (lines 1 - 33)	210,206	229,182	$ 3,701,334 *	$ 16.15	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,285	1.3	35
36	Medical Director		26,091	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant		481	10.3	38
39	Pharmacist Consultant		2,394	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		2,496	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,747		49

C. CONTRACT NURSES

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

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XVIII. A. STAFFING AND SALARY COSTS SUPPLEMENTAL SCHEDULE - Line 32 Other Health Care

	Description	1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage
32 A	Secuity	13,143	14,001	$ 117,723	$ 8.41
32 B	Transportation	3,942	4,403	44,030	10.00
32 C	Activity Director - IL	1,781	1,991	34,419	17.29
32 D	Assisted Living	11,005	11,833	163,064	13.78
	Total Line 32	29,871	32,228	$ 359,236	$ 11.15

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Von Goeben	Administrator	0	$ 135,359
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,359

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris, LLP	Legal Services	$ 26,466
Schieff Harden, LLP	Legal Services	6,213
Ungaretti & Harris	Legal Services	28,741
Unsupported	Legal Services	756
Crowe Horwath LLP	Audit/Reimbursement Svcs	84,187
ADP	Payroll Processing	19,169
Dixon Hughes PLLC	Residency Agreement Analysis	4,600
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 170,132

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,320
Unemployment Compensation Insurance	
FICA Taxes	455,682
Employee Health Insurance	655,314
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Senior Management Benefits	20,160
Life Insurance	1,636
401 K Administration	4,511
Employee Appreciation	10,600
Annual Christmas Expense	4,023
Less: Specific AL/IL & Marketing Emp Bene	(145,932)
Less: AL/IL Allocated Benefits	(504,553)
TOTAL (agree to Schedule V, line 22, col.8)	$ 594,761

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	18,053
Health Care Worker Background Check	5,330
(Indicate # of checks performed)	
Patient Background Checks	
Drug Tests	1,278
Dues & Subscriptions	8,113
Licenses & Permits	7,011
Less: AL, Marketing, Lobbying Specific Exp	(3,703)
Less: AL/IL Allocated Dues, Fees, Subs	(22,748)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,334

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,614
In-State Travel	
Seminar Expense	10,927
Less: AL/IL Allocated Seminar Expenses	(7,906)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,635

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

Inv #	Date	GL Acct.	Payee/Vendor	Amount	Comments	Unallowable Cost
1607793	10/29/2010	5446-10-201	Duane Morris, LLP	$ 263	General - Nursing facility matters	
1613794	11/5/2010	5446-10-201	Duane Morris, LLP	301	General - Nursing facility matters (union employee)	
1623301	12/10/2010	5446-10-201	Duane Morris, LLP	258	General - Nursing facility matters (union employee)	
1635948	2/7/2011	5446-10-201	Duane Morris, LLP	4,033	General - Nursing facility matters	
1652910	4/8/2011	5446-10-201	Duane Morris, LLP	3,330	Collective Bargaining Agreement (employee union)	
1664248	5/17/2011	5446-10-201	Duane Morris, LLP	270	General - Nursing facility matters (maintenance employee)	
1664250	5/17/2011	5446-10-201	Duane Morris, LLP	1,470	Collective Bargaining Agreement (employee union)	
1668296	6/6/2011	5446-10-201	Duane Morris, LLP	11,052	Collective Bargaining Agreement (employee union)	
1668295	6/6/2011	5446-10-201	Duane Morris, LLP	45	General - Nursing facility matters (maintenance employee)	
1668294	6/6/2011	5446-10-201	Duane Morris, LLP	5,444	General - Nursing facility matters	
14792051	9/16/2010	5446-10-201	Schieff Harden, LLP	5,052	General Corporate	(5,052)
1469010	4/13/2010	5446-10-201	Schieff Harden, LLP	285	General Corporate	(285)
1519364	10/14/2010	5446-10-201	Schieff Harden, LLP	325	General - Nursing facility matters	
1548270	1/18/2011	5446-10-201	Schieff Harden, LLP	430	General Corporate	(430)
1563796	3/25/2011	5446-10-201	Schieff Harden, LLP	121	General - Nursing facility matters	
8185065	3/31/2010	5446-10-201	Ungaretti & Harris	710	General - Nursing facility matters	
8186367	4/30/2010	5446-10-201	Ungaretti & Harris	355	General - Nursing facility matters	
8190337	8/17/2010	5446-10-201	Ungaretti & Harris	2,515	General - Nursing facility matters	
8191035	9/30/2010	5446-10-201	Ungaretti & Harris	5,330	General - Nursing facility matters	
8194235	12/31/2010	5446-10-201	Ungaretti & Harris	2,008	General - Nursing facility matters	
8195209	1/31/2011	5446-10-201	Ungaretti & Harris	2,569	General - Nursing facility matters	
8195988	2/28/2011	5446-10-201	Ungaretti & Harris	3,833	General - Nursing facility matters	
8196973	3/31/2011	5446-10-201	Ungaretti & Harris	2,484	General - Nursing facility matters	
8197971	4/30/2011	5446-10-201	Ungaretti & Harris	1,996	General - Nursing facility matters	
8199705	6/30/2011	5446-10-201	Ungaretti & Harris	6,758	General - Nursing facility matters	
8193383	11/30/2010	5446-10-201	Ungaretti & Harris	183	General - Nursing facility matters	
			Unsupported legal expenses	756		(756.00)
			Total Invoices	**$ 62,176**		$ (5,767)
			Unallowable costs	(5,767)		
			Net Legal Services	$ 56,409		
			Total Legal Expenses per General Ledger	$ 62,176		
			Variance	$ -		

Facility Name & ID Number Montgomer # 0037515 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

Date	Payee	Topic	Attendee	Job Class	Location	Fee
10/31/10-11/3/10	AAHSA	Annual Meeting & Exposition	M. Apa	CEO	Los Angles	$ 695
10/31/10-11/3/10	AAHSA	Annual Meeting & Exposition	M. VonGoeben	ADMINSTRATOR	Los Angles	695
10/31/10-11/3/10	AAHSA	Annual Meeting & Exposition	S. Stewart	CFO	Los Angles	695
5/6/2011	Fred Pryor Seminars	Training Rewards Membership	E. Ayot	ACCOUNTANT	Chicago	199
5/27/2010	LSNI	MDS 3.0 Your Path to Successful Implementation	S. Green	MDS	Chicago	650
5/27/2010	LSNI	MDS 3.0 Your Path to Successful Implementation	B. Covington	DON	Chicago	650
3/1/2011	Northern Illinois University (LSN)	LSN	R. Santiago, F. Savino, M. Apa, D. Frank.in, L. Colbert	ADMIN	Chicago	1,059
3/1/2011	Northern Illinois University (LSN)	LSN	B. Jansma	DIRECTOR OF ES	Chicago	176
3/1/2011	Northern Illinois University (LSN)	LSN	M. DiMaggio, A. Pascual	DINNING SERVICES	Chicago	353
3/1/2011	Northern Illinois University (LSN)	LSN	L. Williams	SOCIAL SERVICES	Chicago	353
3/1/2011	Northern Illinois University (LSN)	LSN	A. Camacho	ADMISSIONS	Chicago	176
3/1/2011	Northern Illinois University (LSN)	LSN	G. Mathis	ACTIVITIES HCP	Chicago	176
3/1/2011	Northern Illinois University (LSN)	LSN	G. Walker	NURSING	Chicago	529
3/1/2011	Northern Illinois University (LSN)	LSN	M. Stout	NURSING	Chicago	176
5/23/2011	Skillpath Seminars	Business Writing Basics	L. Colbert	OFFICE MANAGER	Chicago	168
9/1/2010	Fred Pryor Seminars	Access 2003	E. Ayot	ACCOUNTANT	Chicago	109
4/29/2011	Fred Pryor Seminars	Payroll law 2011	E. Ayot	ACCOUNTANT	Chicago	199
11/10/2010	Mather LifeWays Institute on Aging	Moving Toward a New Paradigm in Whole Person Wellness	M. VonGoeben	ADMINSTRATOR	Evanston	1,040
4/7/11, 4/14/11	Rush Alzheimer's Disease Center	C N A conference	C. Hall, J. Joyce, D. Williams, T. Harris, S. Morgan, W. Nicholson, K. Green	NURSING	Chicago	415
12/13/2010	Coalition for Leadership in Aging	Certification for Aging Service Professionals	L. Colbert	OFFICE MANAGER	Baltimore	1,007
12/13/2010	Coalition for Leadership in Aging	Certification for Aging Service Professionals	A. Camacho	ADMISSIONS	Baltimore	1,007
10/26/2010	CPR	CPR Class	Nursing Staff	NURSING	Chicago	399
					Subtotal - Seminars	**10,927**
Related Air Travel						1,614
					Total Travel & Seminars	**$ 12,541**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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 & AAHSA $6,450**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,207** 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. $ **16,380**
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 (AL/IL)** 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? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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 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.