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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 7/1/2011 to 6/30/2012 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: 7/1/2011 Ending: 6/30/2012

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 N/A

	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	14,640	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	14,640	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	1,328	6,623	5,081	13,032	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,328	6,623	5,081	13,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.02%

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 4,472

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	775,900	114,518	62,471	952,889		952,889	(614,519)	338,370			1
2	Food Purchase		655,037		655,037		655,037	(431,744)	223,293			2
3	Housekeeping	228,344	52,513	4,173	285,030		285,030	(278,102)	6,928			3
4	Laundry	57,543	13,517		71,060		71,060	(11,322)	59,738			4
5	Heat and Other Utilities			399,467	399,467		399,467	(388,073)	11,394			5
6	Maintenance	286,412	32,965	324,183	643,560		643,560	(406,634)	236,926			6
7	Other (specify):*											7
8	TOTAL General Services	1,348,199	868,550	790,294	3,007,043		3,007,043	(2,130,394)	876,649			8
	B. Health Care and Programs											
9	Medical Director			26,091	26,091		26,091		26,091			9
10	Nursing and Medical Records	1,303,997	53,027	22,755	1,379,779		1,379,779	(142)	1,379,637			10
10a	Therapy		2,119	635,295	637,414		637,414		637,414			10a
11	Activities	85,069	1,936	9,825	96,830		96,830		96,830			11
12	Social Services	62,218			62,218		62,218		62,218			12
13	CNA Training											13
14	Program Transportation	50,176	173	9,953	60,302		60,302	(42,522)	17,780			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,501,460	57,255	703,919	2,262,634		2,262,634	(42,664)	2,219,970			16
	C. General Administration											
17	Administrative					113,182	113,182	(70,769)	42,413			17
18	Directors Fees											18
19	Professional Services			358,907	358,907	(21,670)	337,237	(240,714)	96,523			19
20	Dues, Fees, Subscriptions & Promotions			37,435	37,435	40	37,475	(24,939)	12,536			20
21	Clerical & General Office Expenses	813,973	15,853	258,529	1,088,355	(113,174)	975,181	(660,445)	314,736			21
22	Employee Benefits & Payroll Taxes			906,407	906,407	2,665	909,072	(500,639)	408,433			22
23	Inservice Training & Education											23
24	Travel and Seminar			26,001	26,001	(2,690)	23,311	(15,785)	7,526			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			157,498	157,498		157,498	(153,006)	4,492			26
27	Other (specify):* Unallowable Costs			(539)	(539)		(539)	539				27
28	TOTAL General Administration	813,973	15,853	1,744,238	2,574,064	(21,647)	2,552,417	(1,665,758)	886,659			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,663,632	941,658	3,238,451	7,843,741	(21,647)	7,822,094	(3,838,816)	3,983,278			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:** 7/1/2011 **Ending:** 6/30/2012

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			2,406,104	2,406,104		2,406,104	(2,035,122)	370,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,980,568	1,980,568		1,980,568	(1,925,838)	54,730			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			41,521	41,521		41,521	(25,962)	15,559			35
36	Other (specify):*					21,647	21,647	(13,535)	8,112			36
37	**TOTAL Ownership**			4,428,193	4,428,193	21,647	4,449,840	(4,000,457)	449,383			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		180,601	23,709	204,310		204,310		204,310			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,119	50,119		50,119		50,119			42
43	Other (specify):* **AL/IL & Mktg**	507,073	12,365	678,598	1,198,036		1,198,036	(1,198,036)				43
44	**TOTAL Special Cost Centers**	507,073	192,966	752,426	1,452,465		1,452,465	(1,198,036)	254,429			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,170,705	1,134,624	8,419,070	13,724,399		13,724,399	(9,037,309)	4,687,090			45

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

SCHEDULE V, COLUMN 5 - RECLASSIFICATIONS

		To Line	From Line
Administrator wages	$ 113,182	17	21
Annual filing fee for Form AG990-IL	15	20	19
Postage	8	21	19
Engineer assistance with kitchen renovations	15,647	36	19
Service for arbitrage calculation on bonds	6,000	36	19
Background check	25	20	24
Employee benefits	2,665	22	24

SCHEDULE V, PART D OWNERSHIP, LINE 36 DETAIL

Engineer assistance with kitchen renovations	$ 15,647
Service for arbitrage calculation on bonds	6,000
Total	$ 21,647

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	(25,414)	2		4
5	Telephone, TV & Radio in Resident Rooms	(63,513)	21		5
6	Rented Facility Space	(25,368)	3		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,184)	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	(1,906,654)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(36,000)	21		17
18	Fines and Penalties	(1,399)	27		18
19	Entertainment				19
20	Contributions	(125)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,063	27		24
25	Fund Raising, Advertising and Promotional	(903,604)	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 Page 5A	(6,058,111)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,037,309)		$	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))**	$ (9,037,309)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Montgomery Place

ID# **0037515**

Report Period Beginning: **7/1/2011**

Ending: **6/30/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL Dietary Costs	$ (614,519)	1	1
2	AL/IL Food Purchases	(405,526)	2	2
3	Rev Offset - Vending	(804)	2	3
4	AL/IL Housekeeping	(235,966)	3	4
5	Rev Offset - Housekeeping	(15,918)	3	5
6	Rev Offset - Housekeeping	(850)	3	6
7	Rev Offset - Laundry	(11,322)	4	7
8	AL/IL Heat & other utilities	(388,073)	5	8
9	Rev Offset - Miscellaneous Services	(1,870)	6	9
10	Rev Offset - Repairs/Upgrades	(9,430)	6	10
11	AL/IL Maintenance	(395,334)	6	11
12	Rev Offset - Med Records	(142)	10	12
13	AL/IL Transportation	(29,667)	14	13
14	Rev Offset - Transportation	(12,855)	14	14
15	AL/IL Administrator	(70,769)	17	15
16	AL/IL Professional Svc	(161,058)	19	16
17	Unallowable Legal	(79,656)	19	17
18	AL/IL Dues, Fees, Subs	(20,917)	20	18
19	AL/IL LSN Expenses	(2,574)	20	19
20	Lobbying Expenses	(1,448)	20	20
21	AL/IL Office & Clerical	(525,168)	21	21
22	Bank Charges	(62)	21	22
23	Rev Offset - WIFI to the extent of exp	(10,040)	21	23
24	Music Fund Expenses	(305)	21	24
25	Library Fund Expenses	(1,622)	21	25
26	Rev Offset - Other Miscellaneous	(23,735)	21	26
27	Marketing Employee Benefits	(53,490)	22	27
28	AL/IL Specific Employee Benefits	(64,611)	22	28
29	AL/IL Allocated Employee Benefits	(382,538)	22	29
30	AL/IL Travel & Seminar	(12,558)	24	30
31	Unsupported travel & seminar	(3,227)	24	31
32	AL/IL Insurance	(153,006)	26	32

33	AL/IL Equip depn	**(2,035,122)**	**30**	**33**
34	AL/IL Equip rental	**(25,962)**	**35**	**34**
35	AL/IL Other Ownership	**(13,535)**	**36**	**35**
36	AL/IL Specific Expenses	**(294,432)**	**43**	**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**	(6,058,111)		**49**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	(614,519)	0	0	0	0	0	0	0	0	0	0	(614,519)	1
2	Food Purchase	(431,744)	0	0	0	0	0	0	0	0	0	0	(431,744)	2
3	Housekeeping	(278,102)	0	0	0	0	0	0	0	0	0	0	(278,102)	3
4	Laundry	(11,322)	0	0	0	0	0	0	0	0	0	0	(11,322)	4
5	Heat and Other Utilities	(388,073)	0	0	0	0	0	0	0	0	0	0	(388,073)	5
6	Maintenance	(406,634)	0	0	0	0	0	0	0	0	0	0	(406,634)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,130,394)	0	0	0	0	0	0	0	0	0	0	(2,130,394)	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	(142)	0	0	0	0	0	0	0	0	0	0	(142)	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	(42,522)	0	0	0	0	0	0	0	0	0	0	(42,522)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(42,664)	0	0	0	0	0	0	0	0	0	0	(42,664)	16
	C. General Administration													
17	Administrative	(70,769)	0	0	0	0	0	0	0	0	0	0	(70,769)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(240,714)	0	0	0	0	0	0	0	0	0	0	(240,714)	19
20	Fees, Subscriptions & Promotions	(24,939)	0	0	0	0	0	0	0	0	0	0	(24,939)	20
21	Clerical & General Office Expenses	(660,445)	0	0	0	0	0	0	0	0	0	0	(660,445)	21
22	Employee Benefits & Payroll Taxes	(500,639)	0	0	0	0	0	0	0	0	0	0	(500,639)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(15,785)	0	0	0	0	0	0	0	0	0	0	(15,785)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(153,006)	0	0	0	0	0	0	0	0	0	0	(153,006)	26
27	Other (specify):*	539	0	0	0	0	0	0	0	0	0	0	539	27
28	**TOTAL General Administration**	(1,665,758)	0	0	0	0	0	0	0	0	0	0	(1,665,758)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,838,816)	0	0	0	0	0	0	0	0	0	0	(3,838,816)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	(2,035,122)	0	0	0	0	0	0	0	0	0	0	(2,035,122)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,925,838)	0	0	0	0	0	0	0	0	0	0	(1,925,838)	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	(25,962)	0	0	0	0	0	0	0	0	0	0	(25,962)	35
36	Other (specify):*	(13,535)	0	0	0	0	0	0	0	0	0	0	(13,535)	36
37	**TOTAL Ownership**	(4,000,457)	0	0	0	0	0	0	0	0	0	0	(4,000,457)	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):*	(1,198,036)	0	0	0	0	0	0	0	0	0	0	(1,198,036)	43
44	**TOTAL Special Cost Centers**	(1,198,036)	0	0	0	0	0	0	0	0	0	0	(1,198,036)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,037,309)	0	0	0	0	0	0	0	0	0	0	(9,037,309)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 ☐ 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: 7/1/2011 Ending: 6/30/2012

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	N/A								$		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: 7/1/2011 Ending: 6/30/2012

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	110,206	2	$ 952,889	$ 775,900	39,134	$ 338,370	1
2	2	Food	Meals	110,206	2	628,819		39,134	223,293	2
3	3	Housekeeping	Square Feet	203,488	2	242,894	228,344	5,804	6,928	3
4	5	Utilities	Square Feet	203,488	2	399,467		5,804	11,394	4
5	6	Maintenance	Revenue	11,610,481	2	632,260	286,412	4,350,783	236,926	5
6	14	Program Transportation	Revenue	11,610,481	2	47,447	37,321	4,350,783	17,780	6
7	17	Administrative	Revenue	11,610,481	2	113,182	113,182	4,350,783	42,413	7
8	19	Professional Fees	Revenue	11,610,481	2	257,581		4,350,783	96,523	8
9	20	Dues and Subscriptions	Revenue	11,610,481	2	33,453		4,350,783	12,536	9
10	21	Clerical & General Office	Revenue	11,610,481	2	839,904	700,791	4,350,783	314,736	10
11	22	Employee Benefits	Salary	4,170,705	2	790,971		2,157,192	408,433	11
12	23	Inservice Training	Revenue	11,610,481	2	0		4,350,783	0	12
13	24	Travel & Seminar	Revenue	11,610,481	2	20,084		4,350,783	7,526	13
14	26	Insurance	Square Feet	203,488	2	157,498		5,804	4,492	14
15	30	Depreciation	Actual	2,406,104	2	2,406,104		370,982	370,982	15
16	32	Interest	Square Feet	203,488	2	1,918,847		5,804	54,730	16
17	35	Equipment Rental	Revenue	11,610,481	2	41,521		4,350,783	15,559	17
18	36	Other Ownership	Revenue	11,610,481	2	21,647		4,350,783	8,112	18
19	4	Laundry	Actual	59,738	1	59,738	57,543	59,738	59,738	19
20	9	Medical Director	Actual	26,091	1	26,091		26,091	26,091	20
21	10	Nursing/Medical Records	Actual	1,379,637	1	1,379,637	1,303,997	1,379,637	1,379,637	21
22	10A	Therapy	Actual	637,414	1	637,414		637,414	637,414	22
23	11	Activities	Actual	96,830	1	96,830	85,069	96,830	96,830	23
24	12	Social Services	Actual	62,218	1	62,218	62,218	62,218	62,218	24
25	TOTALS					$ 11,766,496	$ 3,650,777		$ 4,432,661	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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				$ 11,766,496	$ 3,650,777		$ 4,432,661	1
2	39	Ancillary	Actual	204,310	1	204,310		204,310	204,310	2
3	42	Provider Participation Fee	Actual	50,119	1	50,119		50,119	50,119	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					$ 12,020,925	$ 3,650,777		$ 4,687,090	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 32,740,000	5/15/2038	5.4940	$ 1,938,031	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 40,850,000	$ 32,740,000			$ 1,938,031	9
	B. Non-Facility Related*											
10	Remove AL/IL portion of interest expense										(1,864,117)	10
11	Interest income offset (PG5, Line 10)										(19,184)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,883,301)	14
15	TOTALS (line 9+line14)						$ 40,850,000	$ 32,740,000			$ 54,730	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: 7/1/2011 Ending: 6/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT =PG1!C43

TELEPHONE =PG1!N43 FAX #: (773) 752-0056

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

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	Carpeting	2012	1,193		20				40
41	Elevator cabinet	2012	56		20				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 building depreciation expense and accumulated depreciation			282,197		282,197		3,578,693	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)		$ 6,363,333	$ 282,197		$ 282,197	$	$ 3,578,693	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: 7/1/2011 Ending: 6/30/2012

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	$ 1,218,535	$ 88,784	$ 88,784	$	10	$ 287,696	71
72	Current Year Purchases	4,833				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,223,368	$ 88,784	$ 88,784	$		$ 287,696	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	$ 1,382	76
77	Facility	2005 Glaval Universal Bus	2004	12,922				5	12,922	77
78	Facility	Auto	2007	4,110				5	4,110	78
79										79
80	TOTALS			$ 18,414	$	$	$		$ 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)	$ 8,496,540	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 370,981	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 370,981	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)	$ 3,884,803	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	$ 45,745,739	$ 2,035,123	$ 20,934,910	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 45,745,739	$ 2,035,123	$ 20,934,910	91

G. Construction-in-Progress

	Description	Cost	
92	Upgrades to bldg and IT	$ 349,117	92
93			93
94			94
95		$ 349,117	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: 7/1/2011 Ending: 6/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 41,521 Description: Postage Meter $2,858; Copiers $15,507; Other Admin Equipment $23,156
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A.3	hrs	$	3,638	$ 236,433	$ 676	3,638	$ 237,109	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		198	14,117		198	14,117	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		5,922	384,745	1,443	5,922	386,188	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			$	9,758	$ 635,295	$ 2,119	9,758	$ 637,414	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.

STATE OF ILLINOIS

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2012 (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	$ 2,718,636	$	1
2	Cash-Patient Deposits	667,921		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (102,197))	346,426		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,575		6
7	Other Prepaid Expenses	57,969		7
8	Accounts Receivable (owners or related parties)	191,613		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,020,140	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,768,182		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	45,691,717		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,296,950		16
17	Accumulated Depreciation (book methods)	(24,819,713)		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	349,117		22
23	Other(specify): See Supplemental Schedule	8,966,368		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 46,506,233	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 50,526,373	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 437,515	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,409,734		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	523,349		36
37	Rounding	1		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,370,599	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	33,305,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Original Issue Premium, net	501,351		43
44	See Supplemental Schedule	21,560,505		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 55,366,856	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 57,737,455	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,211,082)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 50,526,373	$	48

*(See instructions.)

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Assets

Description	Amount
Assets limited as to use - Bond funds	$ 7,905,170
Bond financing costs, net	1,010,575
Assets limited as to use - donor restricted	50,623
	$ 8,966,368

Line 44 - Other Long-term Liabilities

Description	Amount
Due to affiliate - Church Home	$ 2,804,326
Refundable entrance fees, net of amortization	17,079,287
Nonrefundable entrance fees, net of amortization	1,676,892
	##########

Facility Name & ID Number Montgomery Place **#** 0037515 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,938,476)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,938,476)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,289,392)	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)**	$ (1,289,392)	17	
	B. Transfers (Itemize):			
18	**Less temporarily restricted FYE 6/30/2011**	(41,737)	18	
19	**Temporarily restricted FYE 6/30/2012**	58,523	19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 16,786	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (7,211,082)	24	*

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,350,783	1
2	Discounts and Allowances for all Levels	(1,489,738)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,861,045	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,072,759	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,072,759	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	10,040	13
14	Non-Patient Meals	25,414	14
15	Telephone, Television and Radio	109,828	15
16	Rental of Facility Space	25,368	16
17	Sale of Drugs	159,471	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,270	19
20	Radiology and X-Ray	7,450	20
21	Other Medical Services	160,045	21
22	Laundry	11,322	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 549,208	23
	D. Non-Operating Revenue		
24	Contributions	252,725	24
25	Interest and Other Investment Income***	185,121	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 437,846	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	7,514,149	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,514,149	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,435,007	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,007,043	31
32	Health Care	2,262,634	32
33	General Administration	2,574,064	33
	B. Capital Expense		
34	Ownership	4,428,193	34
	C. Ancillary Expense		
35	Special Cost Centers	1,402,346	35
36	Provider Participation Fee	50,119	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,724,399	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,289,392)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,289,392)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 172,624	44
45	Private Pay - Net Inpatient Revenue	1,529,907	45
46	Medicare - Net Inpatient Revenue	1,074,700	46
47	Other-(specify) Hospice	73,303	47
48	Other-(specify) Private Insurance	10,511	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,861,045	49

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

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

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

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

Facility Name & ID Number **Montgomery Place** **#** **0037515** **Report Period Beginning:** **7/1/2011** **Ending:** **6/30/2012**

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	$ 7,259,698
CH Admin Fee & Fee Revenue from HPHCS [1]	36,000
Cell Tower Revenue	45,310
Employee, Music, Library, Resident, and Care Assum Funds	1,075
Housekeeping Services	15,068
Massage Revenue	2,050
Medical Records Income	45
Miscellaneous Income	34,998
Miscellaneous Services	1,870
Transportation	12,855
Non-Resident Garage	104,376
Vending	804
	$ 7,514,149

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	1,752	2,271	$ 143,226	$ 63.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,060	7,217	235,704	32.66	3
4	Licensed Practical Nurses	16,657	18,221	446,534	24.51	4
5	CNAs & Orderlies	31,478	34,005	368,938	10.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	1,881	41,102	21.85	9
10	Activity Assistants	4,910	4,756	43,967	9.24	10
11	Social Service Workers	1,506	785	14,431	18.38	11
12	Dietician	1,632	1,665	32,466	19.50	12
13	Food Service Supervisor	3,164	3,176	81,562	25.68	13
14	Head Cook	1,064	986	22,435	22.75	14
15	Cook Helpers/Assistants	51,557	50,330	547,130	10.87	15
16	Dishwashers	9,912	9,537	92,307	9.68	16
17	Maintenance Workers	6,776	7,314	160,112	21.89	17
18	Housekeepers	20,230	21,906	228,344	10.42	18
19	Laundry	4,464	4,226	57,543	13.62	19
20	Administrator	1,832	1,910	113,182	59.26	20
21	Assistant Administrator					21
22	Other Administrative	11,280	11,240	503,856	44.83	22
23	Office Manager	5,772	5,515	108,884	19.74	23
24	Clerical	1,944	1,811	88,050	48.62	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	2,049	2,282	44,455	19.48	31
32	Other Health C See supplemental s	1,971	2,156	65,141	30.21	32
33	Other(specify) See supplemental s	38,757	41,020	731,336	17.83	33
34	TOTAL (lines 1 - 33)	227,679	234,210	$ 4,170,705 *	$ 17.81	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	1,247	$ 62,336	1.3	35
36	Medical Director	240	26,091	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	64	2,225	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	65	2,288	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,616	$ 92,940		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)		$		53

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	MDS Coordinator	1,971	2,156	$ 65,141	$ 30.21
	Total Line 32	**1,971**	**2,156**	**$ 65,141**	**$ 30.21**

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

	Description	1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage
33 A	Marketing	6,727	7,756	$ 260,059	$ 33.53
33 B	Pastorial Care	1,884	962	47,788	49.68
33 C	Transportation	3,984	4,207	50,610	12.03
33 D	Security	9,194	9,752	125,865	12.91
33 E	Activity Director - IL	1,968	2,099	45,922	21.88
33 F	Assisted Living	15,000	16,244	201,092	12.38
	Total Line 33	**38,757**	**41,020**	**$ 731,336**	**$ 17.83**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Von Goeben	Administrator	0%	$ 113,182
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,182

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	Legal Services	$ 155,579
Vertext National Deposition & Litiga	Legal Services	439
V. Henderson / Accrual Adj.	Settlement / Accrued Legal Fees	41,000
Schiff Hardin LLP	Legal Services	25,835
Ungaretti & Harris	Legal Services	40,812
Neal, Gerber, Eisenberg	Legal Services	5,000
ADP	Payroll Processing Fees	18,722
Crowe Horwath LLP	Audit/Reimbursement Svc	36,000
IL Charity Bureau Fund	Annual Filing Fee	15
CCHodgson/Abbot/Enrique J Unanc	IDPH Conservatory Tag Consul	13,858
Metro Design Associates	Engineer - Kitchen Renovations	15,647
Icemakers	Bond Arbitrage Calculations	6,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 358,907

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,442
Unemployment Compensation Insurance	
FICA Taxes	492,693
Employee Health Insurance	298,472
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Senior Mgmt Benefits Pkg & Bonus	26,000
Voluntary Benefits	(2,209)
Life Insurance	814
401K Admin Expense	4,500
Employee Appreciation / Christmas Expense	9,360
Less: Marketing Employee Benefits/PR Taxes	(53,490)
Less: AL/IL Employee Benefits & PR Taxes	(447,149)
TOTAL (agree to Schedule V, line 22, col.8)	$ 408,433

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,129
Health Care Worker Background Check	731
(Indicate # of checks performed)	
Patient Background Checks	
Drug Tests	1,039
Dues & Subscriptions	15,323
Licenses / Permit Fees	4,253
Less: Lobbying Expenses	(1,448)
Less: Allocated AL/IL Expenses	(23,491)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,536

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,538
In-State Travel	
Seminar Expense	11,843
Out-of-State Seminar Expense	1,703
Less: Allocated AL/IL Expenses	(12,501)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,583

* Attach copy of IMRF notifications

**See instructions.

STATE OF ILLINOIS

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

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

Inv #	Date	GL Acct.	Payee/Vendor	Amount	
1679705	7/13/2011	5446-10-201	Duane Morris	$ 3,462.50	Dual eligible treatment and issues, discussior
1679706	7/13/2011	5446-10-201	Duane Morris	7,075.48	Prepare and conduct collective bargaining (C
1685874	8/8/2011	5446-10-201	Duane Morris	1,183.50	NHCA and IDPH regulation regarding pastora
1685875	8/8/2011	5446-10-201	Duane Morris	15,023.56	Collective bargaining issues and steward trai
1694611	9/13/2011	5446-10-201	Duane Morris	485.50	Notice of involuntary discharge or transfer.
1694612	9/13/2011	5446-10-201	Duane Morris	810.00	Grievance documentation and waiver issue.
1694613	9/13/2011	5446-10-201	Duane Morris	18,118.93	Collective bargaining negotiatons.
1704757	10/18/2011	5446-10-201	Duane Morris	345.00	Review auditor's request for information.
1704758	10/18/2011	5446-10-201	Duane Morris	8,053.35	Collective bargaining negotiations -health and
1712779	11/15/2011	5446-10-201	Duane Morris	4,455.00	Collective bargaining negotiations, review of
1718415	12/8/2011	5446-10-201	Duane Morris	10,333.40	Collective bargaining negotiations, stike conti
1718416	12/8/2011	5446-10-201	Duane Morris	8,731.00	LSC survey, consultations, and response to I
1727977	1/18/2012	5446-10-201	Duane Morris	12,972.09	Collective bargaining negotiatons and possibl
1727978	1/18/2012	5446-10-201	Duane Morris	371.69	LSC survey and temporary POC/AOC waiver
1734950	2/1/2012	5446-10-201	Duane Morris	3,532.00	CBA and ratification issues, health and welfa
1734951	2/10/2012	5446-10-201	Duane Morris	7,380.00	IDPH notice and compliance issues.
1745183	3/16/2012	5446-10-201	Duane Morris	6,674.00	Frierson grievance, Lomax grievance, prepar
1745184	3/16/2012	5446-10-201	Duane Morris	4,747.00	Frierson grievance, payroll training, CBA - rev
1745185	3/16/2012	5446-10-201	Duane Morris	7,994.00	LSC survey and temporary waiver, meetings
1754445	4/18/2012	5446-10-201	Duane Morris	1,482.00	Private pay / Medicare certified bed issues.
1754446	4/18/2012	5446-10-201	Duane Morris	8,272.00	CBA training with management, Lomax grieva
1754448	4/18/2012	5446-10-201	Duane Morris	1,689.03	Collective bargaining agreement, printing and
1754449	4/18/2012	5446-10-201	Duane Morris	4,387.00	Annual Life Safety Code Survey issues status
1758433	5/4/2012	5446-10-201	Duane Morris	11,280.00	Employment Matters - waitstaff layoffs, Friers
1769593	6/13/2012	5446-10-201	Duane Morris	6,721.00	Follow-up of CBA meeting, Anderson grievan
			Total Invoices - Duane Morris	**155,579.03**	
CHI60392	12/15/2011	5446-10-201	**Veritext National Deposition & Litigation Servic**	**438.75**	Court reporting services regarding Montefrio-
Email	5/24/2012	5446-10-201	**Approval of settlement agreement**	**1,000.00**	V. Henderson settlement agreement IL Dept.
1637059	12/15/2011	5446-10-201	Schiff Hardin LLP	10,268.75	Care Connect contract, Satellite TV contract,

1645192	1/20/2012	5446-10-201	Schiff Hardin LLP	15,566.00	AOD software license agreement - draft list o
			Total Invoices - Schiff Hardin LLP	**25,834.75**	
8201289	7/31/2011	5446-10-201	Ungaretti & Harris	7,780.35	Assisted/Independent Living (AL/IL) issues
8201837	8/17/2011	5446-10-201	Ungaretti & Harris	1,579.10	IL resident estate matters, HPHCS home ser
8204196	10/31/2011	5446-10-201	Ungaretti & Harris	14,270.07	IL resident probate matter related to estate/tr
8205066	11/30/2011	5446-10-201	Ungaretti & Harris	2,017.50	IL resident memorandum regarding dismiss a
8205997	12/31/2011	5446-10-201	Ungaretti & Harris	1,401.95	IL resident distribution of funds and executior
8207448	2/28/2012	5446-10-201	Ungaretti & Harris	4,003.25	Assited/Independent Living issues.
8208426	3/31/2012	5446-10-201	Ungaretti & Harris	5,998.75	AL/IL/Church Home matters, NF resident mat
8209459	4/30/2012	5446-10-201	Ungaretti & Harris	2,156.25	IL related matters
8210612	5/31/2012	5446-10-201	Ungaretti & Harris	1,605.00	AL/IL related matters
			Total Invoices - Ungaretti & Harris	**40,812.22**	
207769	6/21/2012	5446-10-201	**Neal, Gerber, Eisenberg**	**5,000.00**	Employee matter
			Accrued legal fees	**40,000.00**	No support provided, see FS auditor wp (atta

Total Legal Invoices (rounded)	**$**	**268,665**	**[A]**
Unallowable legal expenses		**(79,656)**	
Net Legal Services	**$**	**189,009**	
Total Legal Expenses per General Ledger	**$**	**268,665**	**[B]**
Variance	**$**	**-**	**[A] - [B]**

Comments	Unallowable Cost
n of downsizing of medicaid distinct part.	
BA) negotiations.	
al care.	
ning time allowance.	
l welfare proposal, economic proposal and related issues.	
outstanding grievances.	
ngency plan.	
DPH, LSC POC, including multiple exhibits.	
le stike preparation.	
requests.	
re issues, FLMA issues, retro pay issues.	
e for CBA/Arbitration/Jarassment training presentation.	
view and assess final issues.	
/ discussions with IDPH/architech regarding same.	
ance, Frierson grievance, Gary grievance	
l duplicating of agreement.	
s / response to IDPH related to same.	
on termination, CBA related issues regarding same.	
ce, preparation for and conduct sexual harassment training.	
	-
Corrales v. Montgomery Place	-
of Human Rights.	1,000.00
software license agreement - review / discussions related to same.	

f issues / revisions / HIPPA provisions.	
	-
	7,780.35
vices agreement review and revision.	1,579.10
ust/will.	14,270.07
nd disallow citation.	2,017.50
of receipts, file receipt of distribution filing at Circuit Court.	1,401.95
	4,003.25
tter	3,842.50
	2,156.25
	1,605.00
	38,655.97
ched)	**40,000.00**
Total Unallowable Legal Expenses (rounded)	**$ 79,656**

STATE OF ILLINOIS

Facility Name & ID Number Montgomer # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

Date	Payee	Topic	Attendee	Job Class
8/24/2011	Cynthia Chow	Nutrition in a long term care setting	M. DiMaggio	Management
10/6/2011	Gary Gilles	The Ethics of Caregiving	Admissions	Management
2/6/2012	Fred Pryor	Training Rewards renewal	E. Ayot	Management
3/8/2012	Transformative Dynamics	Expended Leadership Retreat	All Management	Expended Leadership
3/8/2012	Wildfire	Expended Leadership Retreat	All Management	Expended Leadership
5/8/2012	E. Ayot	How to Assess Internal Controls & Safeguard Assets	E. Ayot	Management
10/18/11-10/20/11	Best Western	Activities: Share the Vision and Join the Expedition	G. Mathis	Activity Director
10/18/11-10/20/11	Best Western	Activities: Share the Vision and Join the Expedition	R. Reif	Program Director
10/18/11-10/20/11	R. Reif	Activities: Share the Vision and Join the Expedition	R. Reif & G. Mathis	Program/Activity Directors
10/19/11-10/21/11	IAPA	Activities: Share the Vision and Join the Expedition	R. Reif, G. Mathis	Program/Activity Directors
3/18/12-3/23/12	Fred Pryor	Payroll Law	S. Paraf	Payroll
3/18/12-3/23/12	Fred Pryor	IRS 1099 2012 Update	E. Ayot & S. Paraf	Payroll
3/18/12-3/23/12	R. Reif	Conquering Pain	R. Reif	Program Directors'
3/18/12-3/23/12	Oakton Community College	Ethics and Long Term Care	R. Reif, G. Mathis	Program/Activity Directors
3/18/12-3/23/12	Oakton Community College	Ethics of Caregiving in an Increasingly Complex Health Syste	R. Reif, G. Mathis	Program/Activity Directors
5/2/12-5/4/12	NIU Outreach	LSN Annual Meeting	Management Team	Expended Leadership
		Total Illinois or within 50 miles of Illinois seminar expenses		
3/18/12-3/23/12	Leading Age	AHSA -Leading Age Registration	M. Apa	Management
9/21/11-9/23/11	Broadmoor	Ziegler	M. Apa	Management
9/21/11-9/23/11	Broadmoor	Ziegler	F. Saviano	Management
9/21/11-9/23/11	Broadmoor	Ziegler	F. Saviano	Management
		Total out of area seminar expenses		
10/15/11-10/17/11	United Airlines	AHSA -Leading Age Registration	M. Apa	Management
10/15/11-10/19/11	Southwest Airlines	AHSA -Leading Age Registration	M. VonGoeben	Management
10/15/11-10/19/11	Southwest Airlines	AHSA -Leading Age Registration	M. VonGoeben	Management
10/15/11-10/19/11	Mary VonGoeben	AHSA -Leading Age Registration	M. VonGoeben	Management
10/15/11-10/19/11	Henley Park Hotel	AHSA -Leading Age Registration	M. Apa	Management
10/15/11-10/19/11	Henley Park Hotel	AHSA -Leading Age Registration	M. VonGoeben	Management
10/15/11-10/19/11	M. Apa	AHSA -Leading Age Registration	M. Apa	Management
10/15/11-10/19/11	M. Apa	AHSA -Leading Age Registration	M. Apa	Management
10/15/11-10/19/11	United Airlines	AHSA -Leading Age Registration	M. Apa	Management
10/15/11-10/20/11	United Airlines	Ziegler	M. Apa	Management
9/21/11-9/23/11	Southwest Airlines	AOD	F. Saviano	Finance

9/21/11-9/23/11	American Airlines	Ziegler	F. Saviano	Management
9/21/11-9/23/11	Fred Saviano	Ziegler	F. Saviano	Management
		Total out of area travel expenses		
Less Allocated Assisted/Independent Living Expenses				
Net Expenses - Schedule 5, Line 24, Column 8				

Location	Fee
Chicago	$ 110
Chicago	500
Chicago	299
Chicago	3,721
Chicago	1,513
Chicago	150
Rockford	286
Rockford	286
Rockford	48
Rockford	550
Chicago	199
Chicago	199
Oak Brook	84
Chicago	300
Chicago	89
Chicago	3,509
	11,843
Washington DC	699
Colorado Springs	316
Colorado Springs	316
Colorado Springs	371
	1,703
Washington DC	292
Washington DC	292
Washington DC	24
Washington DC	279
Washington DC	1,826
Washington DC	1,278
Washington DC	85
Washington DC	677
Washington DC	169
Colorado Springs	539
Fort Lauderdale	449

Colorado Springs	512
Colorado Springs	116
	6,538
	(12,558)
	7,526

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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:** 7/1/2011 **Ending:** 6/30/2012

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 $208, LeadingAge $3,970

(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?

(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. $ 24,001 Line 10

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 50,119
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? Yes Indicate the amount. $ 2,711

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes - See seminar detail schedule
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.