FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0037515

Facility Name: Montgomery Place

Address: 5550 South Shore Dr (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: 1/24/1992

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: Joshua Banach **Telephone Number:** (847) 628-8784
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 7/1/19 to 6/30/20 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) Michael Clark
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Denise A Leonard, CPA, Partner
(Firm Name & Address) Plante & Moran PLLC, 1111 Superior Ave. Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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: 7/1/19 Ending: 6/30/20

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	171	5,849	4,825	10,845	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	171	5,849	4,825	10,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.08%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 1/28/1992

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 3,490

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	262,994	37,994	6,570	307,558		307,558		307,558			1
2	Food Purchase		207,421		207,421		207,421		207,421			2
3	Housekeeping	15,480	4,874	862	21,216		21,216		21,216			3
4	Laundry	16,150			16,150		16,150		16,150			4
5	Heat and Other Utilities			27,857	27,857		27,857		27,857			5
6	Maintenance	91,743	40,235		131,978		131,978	2,549	134,527			6
7	Other (specify):* Trash/Refuse			2,426	2,426		2,426		2,426			7
8	**TOTAL General Services**	386,367	290,524	37,715	714,606		714,606	2,549	717,155			8
	B. Health Care and Programs											
9	Medical Director			33,396	33,396		33,396		33,396			9
10	Nursing and Medical Records	1,575,044	135,593	9,515	1,720,152		1,720,152		1,720,152			10
10a	Therapy		10,067	739,204	749,271		749,271		749,271			10a
11	Activities	119,613	9,196	750	129,559		129,559	(4,025)	125,534			11
12	Social Services	63,317		5,004	68,321		68,321		68,321			12
13	CNA Training											13
14	Program Transportation	22,350			22,350		22,350		22,350			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,780,324	154,856	787,869	2,723,049		2,723,049	(4,025)	2,719,024			16
	C. General Administration											
17	Administrative	83,508			83,508		83,508		83,508			17
18	Directors Fees											18
19	Professional Services			235,862	235,862		235,862		235,862			19
20	Dues, Fees, Subscriptions & Promotions			13,153	13,153		13,153		13,153			20
21	Clerical & General Office Expenses	414,484	23,908	296,351	734,743		734,743	(217,058)	517,685			21
22	Employee Benefits & Payroll Taxes			493,632	493,632		493,632		493,632			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,676	1,676		1,676		1,676			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,978	18,978		18,978		18,978			26
27	Other (specify):* Promo/Mktg/Contr	143,094	1,653	173,389	318,136		318,136	(318,136)				27
28	**TOTAL General Administration**	641,086	25,561	1,233,041	1,899,688		1,899,688	(535,194)	1,364,494			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,807,777	470,941	2,058,625	5,337,343		5,337,343	(536,670)	4,800,673			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: 7/1/19 Ending: 6/30/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			240,333	240,333		240,333		240,333			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,554	89,554		89,554		89,554			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,143	23,143		23,143		23,143			35
36	Other (specify):*											36
37	**TOTAL Ownership**			353,030	353,030		353,030		353,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			168,702	168,702		168,702		168,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,286	60,286		60,286		60,286			42
43	Other (specify):* Wellness Ctr		424		424		424	(424)				43
44	**TOTAL Special Cost Centers**		424	228,988	229,412		229,412	(424)	228,988			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,807,777	471,365	2,640,643	5,919,785		5,919,785	(537,094)	5,382,691			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: 7/1/19 Ending: 6/30/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,234)	21		18
19	Entertainment	(4,025)	11		19
20	Contributions	(250)	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	(199,965)	21		24
25	Fund Raising, Advertising and Promotional	(317,886)	27		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	(11,734)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (537,094)		$	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))**	$ (537,094)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Wellness Center Supplies	$ (424)	43	1
2	Bank Charges	(13,859)	21	2
3	Additional R&M Expense	2,549	06	3
4		0		4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(11,734)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,549	0	0	0	0	0	0	0	0	0	0	2,549	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,549	0	0	0	0	0	0	0	0	0	0	2,549	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,025)	0	0	0	0	0	0	0	0	0	0	(4,025)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,025)	0	0	0	0	0	0	0	0	0	0	(4,025)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(217,058)	0	0	0	0	0	0	0	0	0	0	(217,058)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(318,136)	0	0	0	0	0	0	0	0	0	0	(318,136)	27
28	**TOTAL General Administration**	(535,194)	0	0	0	0	0	0	0	0	0	0	(535,194)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(536,670)	0	0	0	0	0	0	0	0	0	0	(536,670)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montgomery Place # 0037515 **Report Period Beginning:** 7/1/19 **Ending:** 6/30/20

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(424)	0	0	0	0	0	0	0	0	0	0	(424)	43
44	**TOTAL Special Cost Centers**	(424)	0	0	0	0	0	0	0	0	0	0	(424)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(537,094)	0	0	0	0	0	0	0	0	0	0	(537,094)	45

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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			$			$	$	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: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors:		None	N/A	Life Care At Home LLC	Chicago, IL	Home Health	1
2					Mont Place Asst. Living	Chicago, IL	Assisted Living	2
3	Michael McGarry				Mont Place Ind. Living	Chicago, IL	Independent Living	3
4	Gregory L Gleason							4
5	Scott Williamson							5
6	Deborah Franczek							6
7	Constance Bonbrest							7
8	Susanne Dutcher							8
9	Bryon Rosner							9
10	Susan Levy							10
11	Margo Brooks-Pugh							11
12	Morag Fullilove							12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	See Board of Directors List on Page 6-Supplemental										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: 7/1/19 Ending: 6/30/20

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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		All costs for AL/IL services are removed from the trial balance. See included exhibits.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	IL Finance Authority		X	Facility (2017 Series)	N/A	5/4/2017	$ 31,085,000	$ 28,749,604	5/15/2048	0.0525	$ 1,609,599	1
2	Revenue Bonds											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 31,085,000	$ 28,749,604			$ 1,609,599	9
	B. Non-Facility Related*											
10	Interest Income		X								(266,285)	10
11	Bond Interest Expense-IL/AL		X								(1,253,760)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,520,045)	14
15	TOTALS (line 9+line14)						$ 31,085,000	$ 28,749,604			$ 89,554	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: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

N/A- Facility Does Not Pay Real Estate Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037515

CONTACT PERSON REGARDING THIS REPORT Joshua Banach

TELEPHONE (847) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 7/1/19 Ending: 6/30/20

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. [X] (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, 19 Units
Montgomery Place Retirement Community Independent Living, 182,851 square feet, 154 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	Facility	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: 7/1/19 Ending: 6/30/20

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			1999	37,217		20				9
10	Various			2000	143,621		20				10
11	Various			2001	117,397		20				11
12	Various			2002	68,258		20				12
13	Various			2003	95,898		20				13
14	Various			2004	76,985		20				14
15	Various			2005	7,058		20				15
16	Various			2006	14,779		20				16
17	Various			2007	12,137		20				17
18	Elevator			2008	3,481		20				18
19	Building canopy & façade			2009	5,788		20				19
20	Carpeting			2010	910		20				20
21	Varous			2012	1,249		20				21
22	Elevator control repair			2013	106		20				22
23	Main Entrance, 1st Floor - Replace Automatic entrance doors (re			2015	7,621		10				23
24	HC Center, 2nd Floor - Replace carpeting in 8 patient rooms (rem			2015	14,292		5				24
25	Main Kitchen, 1st Floor - Replace HVAC & ventalation system (in			2015	12,402		5				25
26	Main Building, 1st Floor - Replace motor and montgomery frieght			2016	2,188		10				26
27	Main Building Entrance, 1st Floor - replace blue awning			2017	483		5				27
28	Main Parking Lot - replace concrete stairs down to public sidewal			2017	97		18				28
29	Main Building, 1-14 Floors - fire alarm system replacement (remo			2017	2,836		18				29
30	Main Building, 1st Floor - install wire glass windows for beauty sa			2017	28		18				30
31	HC Center, 2nd Floor - install new lock system on stairwells for re			2017	1,420		18				31
32	HC Center, 2nd Floor - materials, parts for resident dining and th			2017	618		15				32
33	and therapy space renovations (installation labor and materials0			2017	5,238		15				33
34	dining and therapy spaces (removal labor and materials)			2017	11,925		20				34
35	and therapy space renovations (installation labor and materials)			2017	10,864		18				35
36	(installation labor and materials)			2017	15,865		20				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: 7/1/19 Ending: 6/30/20

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	dining room and therapy space (labor and materials)	2017	$ 36,188	$	20	$	$	$	37
38	and therapy space renovations (installation labor and materials)	2017	18,409		20				38
39	labor and materials)	2017	17,613		20				39
40	Chiller Project (4 total for entire building)	2018	6,232		10				40
41	Cafe First Floor - Cabinets & CounterTops	2018	1,560		10				41
42	Cafe First Floor - Updated Lighting & Electrical	2018	655		10				42
43	Cafe First Floor - Moved Sinks, Plumbing Lines	2018	364		10				43
44	Cafe First Floor - Construction Management	2018	385		10				44
45	Cafe First Floor - Carpenter/ Demo & Install	2018	576		10				45
46	Cafe First Floor - Café Equipment	2018	668		10				46
47	Cafe First Floor - Sprinklers Relocate Heads	2018	67		10				47
48	Cafe First Floor - Painting	2018	105		10				48
49	West Dining Room Remodel - SNF - Updated Lighting & Electrical	2018	4,908		10				49
50	West Dining Room Remodel - SNF - Plumbing	2018	5,529		10				50
51	West Dining Room Remodel - SNF - Construction Management	2018	1,821		10				51
52	West Dining Room Remodel - SNF - Carpenter/ Demo & Install	2018	3,600		10				52
53	West Dining Room Remodel - SNF - Painting	2018	6,917		10				53
54	Administrator's Office - Updated Lighting & Electrical	2018	2,657		10				54
55	Administrator's Office - Moved Sinks, Plumbing Lines	2018	4,675		10				55
56	Administrator's Office - Construction Management	2018	1,800		10				56
57	Administrator's Office - Carpenter/ Demo & Install	2018	5,450		10				57
58	Administrator's Office - Install Fire Door	2018	1,085		10				58
59	Administrator's Office - Painting	2018	4,481		10				59
60	EE Lounge - New Flooring	2019	414		10				60
61	EE Lounge - Construction	2019	359		10				61
62	EE Lounge - Plumbing	2019	19		10				62
63	EE Lounge - Painting	2019	338		10				63
64	Back Flow Preventer Kitchen - updated valves of chemical machine	2019	821		10				64
65	HVAC Rplc - Elara Energy Services - Engineering & Design for up	2019	1,167		10				65
66	HVAC Rplc - Milne Equipment - Boiler	2019	4,068		10				66
67	HVAC Rplc - Gora Plumbing - Plumbing Installation	2019	12,223		10				67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,551,656	$		$	$	$	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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,551,656	$		$	$	$	1
2	Server HVAC - Replace Coil in Make-up Air Unit	2019	240		10				2
3	HVAC Rplc - Elara Energy Services - Engineering & Design for up	2019	1,189		10				3
4	HVAC Rplc - Emcor - Contractor for project	2019	11,479		10				4
5	HVAC Rplc - Elara Energy Services - Engineering & Design for Bo	2019	2,931		10				5
6	HVAC Rplc - AMS Mechanical - Contractor for project	2019	28,300		10				6
7	HVAC Rplc - Vince Neri Power Rodding Plumbing	2019	379		10				7
8	HVAC Rplc - USA Fire Protection	2019	94		10				8
9	Replace Boiler S-1(TC: $109,084)	2019	7,276		10				9
10	Employee Lounge-Renovation/Upgrades(TC: $4,325)	2019	288		10				10
11	S-3 Coil for Kitchen Air Handler(TC: $12,395)	2019	827		10				11
12	Phone Room AC(TC: $5,651)	2019	377		10				12
13	Roof Anchors(TC: $64,469)	2019	4,300		10				13
14	Hair Salon-Updgrades/Renovations (TC: $5,287)	2020	353		10				14
15	Wifi Access Througout Facility (TC: $568,547)	2020	37,922		10				15
16	5th Floor Renovations- Floors/Walls/Rooms (TC: $3,195)	2020	213		10				16
17	7th Floor Hallway Floors/Walls/Rooms(TC: $3,578)	2020	239		10				17
18	Siemens Door Fire Alarms- Through Facility(TC: $4,456)	2020	297		10				18
19	West Entrance Update- Doors, Framing, Ren (TC: $6,232)	2020	416		10				19
20	Signage Through Facility (TC: $8,838)	2020	589		10				20
21	Recieving Area Door(TC: $8,860)	2020	591		10				21
22	Laundry Machine Connect (Electrical/Wiring)(TC: $20,740)	2020	1,383		10				22
23	2nd Floor- Resident Rooms, Stairwell, Bathrooms	2019	250,252		10				23
24	Painting,Blinds,Shelving,Doors & Locks, Carpet & Floors								24
25	Windows, Electrical Work/Lighting Fixtures								25
26									26
27	2nd Floor: Dining Room/Electrical Closet/Resident Rooms:	2020	33,740		10				27
28	Paint(Including Prep/Patch),Fire Alarms,Laminate Floors								28
29	Doors/Hinges, Security System, Cabinets & Shelving,								29
30									30
31	Depreciation Totals			240,333		240,333		5,733,898	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,935,332	$ 240,333		$ 240,333	$	$ 5,733,898	34

**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: 7/1/19 Ending: 6/30/20

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	$ 1,123,936	$	$	$		$	71
72	Current Year Purchases	32,404						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,156,340	$	$	$		$	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	Bus (TC: $86,290)		$ 5,756	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 5,756	$	$	$		$	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)	$ 8,988,853	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 240,333	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 240,333	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)	$ 5,733,898	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	$ 50,516,931	$ 2,048,240	$ 33,532,670	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 50,516,931	$ 2,048,240	$ 33,532,670	91

G. Construction-in-Progress

	Description	Cost	
92	AL/IL/SNF Renovations	$ 834,749	92
93			93
94			94
95		$ 834,749	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: 7/1/19 Ending: 6/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 23,143 Description: $1,667 Oxygen Concentrator; $21,476 Dietary Equipment (Dishwasher and Chlorinator)
(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: 7/1/19 Ending: 6/30/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	V10A	hrs	$	2,558	$ 241,460	$ 10,067	2,558	$ 251,527	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,905	92,770		1,905	92,770	2
3	Licensed Recreational Therapist	V10A	hrs			2,015			2,015	3
4	Licensed Physical Therapist	V10A	hrs		5,926	402,959		5,926	402,959	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs							8
9	Pharmacy	V39	# of prescrpts				144,414		144,414	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					14,210		14,210	12
13	Other (specify): BILLABLE SUPPLIES	V39					10,078		10,078	13
14	TOTAL			$	10,389	$ 739,204	$ 178,769	10,389	$ 917,973	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: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (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	$ 154,108	$	1
2	Cash-Patient Deposits	500		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,494,522		3
4	Supply Inventory (priced at)	5,474		4
5	Short-Term Investments			5
6	Prepaid Insurance	156,574		6
7	Other Prepaid Expenses	48,393		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	23,671		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,883,242	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,196,745		12
13	Land	3,253,612		13
14	Buildings, at Historical Cost	52,129,268		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,350,632		16
17	Accumulated Depreciation (book methods)	(39,565,002)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,414,208		21
22	Other Long-Term Assets (spe See Attached	834,749		22
23	Other(specify): See Attached	900,549		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 33,514,761	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 35,398,003	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 816,853	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	658,844		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	447,465		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	193,086		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	26,536,131		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 28,652,379	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	28,749,604		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached			43
44	See Attached	2,273,086		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 31,022,690	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 59,675,069	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (24,277,066)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 35,398,003	$	48

***(See instructions.)**

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (24,014,248)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (24,014,248)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	701,308	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)**	$ 701,308	17
	B. Transfers (Itemize):		
18	Net IL & AL Activity	(964,126)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (964,126)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (24,277,066)	24 *

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

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 5,023,194	1
2	Discounts and Allowances for all Levels	(1,668,364)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,354,830	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,541,961	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,541,961	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,191	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,147	19
20	Radiology and X-Ray	5,600	20
21	Other Medical Services	70,347	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 280,285	23
	D. Non-Operating Revenue		
24	Contributions	12,036	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,036	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	$1,380,262 CARES, $5,216 Care Giver; $45,412 Gain	1,431,981	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,431,981	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,621,093	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	714,606	31
32	Health Care	2,723,049	32
33	General Administration	1,899,688	33
	B. Capital Expense		
34	Ownership	353,030	34
	C. Ancillary Expense		
35	Special Cost Centers	169,126	35
36	Provider Participation Fee	60,286	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,919,785	40
41	**Income before Income Taxes (line 30 minus line 40)****	701,308	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 701,308	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 33,995	44
45	Private Pay - Net Inpatient Revenue	2,126,568	45
46	Medicare - Net Inpatient Revenue	1,018,058	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	229,827	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(53,618)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,354,830	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 7/1/19 Ending: 6/30/20

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	8,267	9,208	$ 372,315	$ 40.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,742	8,514	308,997	36.29	3
4	Licensed Practical Nurses	11,255	13,268	406,471	30.64	4
5	CNAs & Orderlies	30,360	37,482	487,261	13.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,768	2,138	44,347	20.74	9
10	Activity Assistants	4,176	5,713	75,267	13.17	10
11	Social Service Workers	1,920	2,080	63,317	30.44	11
12	Dietician					12
13	Food Service Supervisor	435	468	11,380	24.32	13
14	Head Cook	1,208	1,317	35,013	26.59	14
15	Cook Helpers/Assistants	12,943	16,102	216,602	13.45	15
16	Dishwashers					16
17	Maintenance Workers	4,509	5,858	91,743	15.66	17
18	Housekeepers	974	1,135	15,480	13.64	18
19	Laundry	858	1,242	16,150	13.00	19
20	Administrator	1,484	1,484	83,508	56.27	20
21	Assistant Administrator					21
22	Other Administrative	1,575	2,129	176,838	83.06	22
23	Office Manager					23
24	Clerical	7,197	8,455	237,646	28.11	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					31
32	Other Health Care:Transportation	1,341	1,621	22,350	13.79	32
33	Other(specify) Marketing/Sales	36,278	41,072	143,094	3.48	33
34	TOTAL (lines 1 - 33)	134,290	159,286	$ 2,807,779 *	$ 17.63	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	Monthy Fees	$ 6,570	V01-03	35
36	Medical Director	Monthy Fees	33,396	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthy Fees	9,515	V10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 49,482		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	84	$ 4,181	V10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	84	$ 4,181		53

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Jansma	Administrator	0.00%	$ 83,508
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,508

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Expense	$ 95,085
Plante Moran	Accounting	19,250
2060 Digital Chicago	Business Consulting	2,435
Allscripts	Healthcare Software	229
AT&T Corporate	Internal Communications	18,512
Connect Care Hero	Data Process-Communication	2,907
Continuum CRM	Discharge/Resident Tracking	3,142
Cyber Savants	Internal Communications	7,025
Dude Solutions	Operations Mgmt Consulting	1,462
E-Solutions	Data Processing	3,788
In Touch Link	Resident Engagement	943
See Supplemental Schedule		81,084
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 235,862

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,034
Unemployment Compensation Insurance	
FICA Taxes	203,988
Employee Health Insurance	147,905
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K Expenses	972
Testing Expenses	9,579
Employee Appreciation	16,424
Other Employee Benefits	58,038
Life Insurance	1,692
TOTAL (agree to Schedule V, line 22, col.8)	$ 493,632

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	7,797
Licenses and Fees	5,355
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,152

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,676
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,676

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Its Never 2 Late	Resident Engagement	$ 749
Matrix Care	Software Expense	41,185
Mother Network Guardian	Internal Communications	7,325
Philips Lifeline	Resident Tracking/Alerts	19
PSD Solutions	IT Firewalls & Server Mgmt	19,669
Senior Portal/Vibrant	Resident Engagement	2,252
Survey Gizmo	Satisfaction/Surveys	116
Verizon	Internal Communications	3,106
Other Various Professional	Data Processing	2,047
VirtuSense	Resident Tracking/Alerts	4,616
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 81,084

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Montgomery Place # 0037515 Report Period Beginning: 7/1/19 Ending: 6/30/20

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? **No**
If YES, give association name and amount. **N/A**

(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? **5-20 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,454** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,286**
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. $ ____ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.