

Facility Name & ID Number MCKINLEY COURT

0042499 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	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	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,152	3,043	7,798	15,993	8
9	SNF/PED					9
10	ICF	22,027	13,008	127	35,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,179	16,051	7,925	51,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.43%

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 NO

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

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/01/97 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 150 and days of care provided 7,211

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number

MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	229,662	30,733	10,431	270,826		270,826	(3,099)	267,727		1
2	Food Purchase		211,562		211,562		211,562	(1,240)	210,322		2
3	Housekeeping	202,837	34,860		237,697		237,697	(2,571)	235,126		3
4	Laundry	115,791	38,432	172	154,395		154,395	(1,708)	152,687		4
5	Heat and Other Utilities			142,206	142,206		142,206		142,206		5
6	Maintenance	82,053	23,450	32,357	137,860		137,860	(422)	137,438		6
7	Other (specify):*			15,596	15,596		15,596		15,596		7
8	TOTAL General Services	630,343	339,037	200,762	1,170,142		1,170,142	(9,040)	1,161,102		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	1,783,685	112,596	88,917	1,985,198		1,985,198	(43,443)	1,941,755		10
10a	Therapy	89,076		1,095	90,171		90,171		90,171		10a
11	Activities	115,782	4,649	12,528	132,959		132,959	(1,725)	131,234		11
12	Social Services	25,443		3,036	28,479		28,479		28,479		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,013,986	117,245	141,576	2,272,807		2,272,807	(45,168)	2,227,639		16
	C. General Administration										
17	Administrative	72,514		546,199	618,713		618,713	(550,374)	68,339		17
18	Directors Fees										18
19	Professional Services			419,985	419,985		419,985	(283,098)	136,887		19
20	Dues, Fees, Subscriptions & Promotions			104,842	104,842		104,842	(75,944)	28,898		20
21	Clerical & General Office Expenses	160,033	24,910	53,347	238,290		238,290	197,669	435,959		21
22	Employee Benefits & Payroll Taxes			547,168	547,168		547,168		547,168		22
23	Inservice Training & Education			4,113	4,113		4,113		4,113		23
24	Travel and Seminar							8,208	8,208		24
25	Other Admin. Staff Transportation			7,685	7,685		7,685		7,685		25
26	Insurance-Prop.Liab.Malpractice			133,694	133,694		133,694	36,671	170,365		26
27	Other (specify):*			12,000	12,000		12,000	(12,000)			27
28	TOTAL General Administration	232,547	24,910	1,829,033	2,086,490		2,086,490	(678,868)	1,407,622		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,876,876	481,192	2,171,371	5,529,439		5,529,439	(733,076)	4,796,363		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	10,431
	REPAIRS & MAINTENANCE		0
			0
			10,431
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		172
			0
			172
5	HEAT & OTHER UTILITIES		
	GAS HEAT		43,303
	ELECTRICITY		90,525
	WATER		8,378
	CABLE TV - LOBBY		0
			0
			142,206
6	MAINTENANCE		
	GROUNDS MAINTENANCE		8,285
	PAINTING & DECORATING		4,800
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		8,689
	ELEVATOR MAINTENANCE & REPAIR		1,176
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		6,282
	FIRE SERVICE		3,125
			0
			0
			0
			32,357
7	OTHER		
	SCAVENGER		15,596
	SECURITY SERVICE		0
			15,596
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	36,000
			36,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,200
	PHARMACY CONSULTANT	XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	86,517
			0
			0
			88,917
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		274
	SPEECH THERAPY SERVICES		263
	OCCUPATIONAL THERAPY SERVICES		558
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			1,095
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		9,284
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,244
			0
			12,528
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	3,036
			0
			3,036
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	546,199
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	31,041
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	388,944
		0
		419,985
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	41,542
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	23,973
	EMPLOYEE WANT ADS XIX F	6,596
	CONTRIBUTIONS VI 20 XIX F	210
	DUES & SUBSCRIPTIONS XIX F	16,631
	LICENSES & PERMITS XIX F	2,835
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	6,787
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,268
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,000
		104,842
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	2,713
	EQUIPMENT REPAIR & MAINTENANCE	4,893
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	1,058
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	41,424
	MESSENGER SERVICE	3,259
		0
		53,347

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	214,752
	UNEMPLOYMENT COMPENSATION XIX D	38,345
	WORKERS COMPENSATION INSURANCE XIX D	76,069
	HOSPITALIZATION INSURANCE XIX D	197,744
	EMPLOYEE BENEFITS - OTHER XIX D	4,690
	EMPLOYEE PHYSICAL EXAMS XIX D	5,987
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,581
	CHICAGO HEAD TAX XIX D	0
		547,168
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,113
		4,113
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	7,685
		7,685
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	133,694
		133,694
27	OTHER	
	BAD DEBTS VI 24	12,000
		12,000

GRAND TOTAL COLUMN 3 OTHER

2,171,371

MCKINLEY COURT
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
 12/31/2005

TOTAL FOOD PURCHASE	211,562	PATIENT MEALS	153465
LESS SALES TAX	(1,240)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	210,322	TOTAL MEALS/YEAR	153465
TOTAL PATIENT CENSUS	51,155	NET FOOD	210322
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	153465

TOTAL PATIENT MEALS	153465	COST PER MEAL	1.37
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MCKINLEY COURT

#0042499

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			72,950	72,950		72,950	252,235	325,185			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			148,320	148,320		148,320	299,414	447,734			32
33	Real Estate Taxes			80,651	80,651		80,651		80,651			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(542,833)	33,167			34
35	Rent-Equipment & Vehicles			16,331	16,331		16,331	11,163	27,494			35
36	Other (specify):* STORAGE			4,905	4,905		4,905		4,905			36
37	TOTAL Ownership			899,157	899,157		899,157	19,979	919,136			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,825	339,068	490,893		490,893		490,893			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		151,825	421,193	573,018		573,018		573,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,876,876	633,017	3,491,721	7,001,614		7,001,614	(713,097)	6,288,517			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(18,081)	30		9
10	Interest and Other Investment Income	(127,103)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,240)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,058)	21		18
19	Entertainment	(41,542)	20		19
20	Contributions	(4,478)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(23,973)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,787)	20		28
29	Other-Attach Schedule	(5,046)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (241,308)		\$	30

OHF 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	2	
		Amount	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)	(471,789)	PG 6-6E	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (471,789)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (713,097)		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

MCKINLEY COURT

ID# 0042499

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 987	6	1
2	VACATION ACCRUAL	(3,099)	1	2
3	VACATION ACCRUAL	(2,571)	3	3
4	VACATION ACCRUAL	(1,708)	4	4
5	VACATION ACCRUAL	(1,409)	6	5
6	VACATION ACCRUAL	6,163	10	6
7	VACATION ACCRUAL	(1,725)	11	7
8	VACATION ACCRUAL	(4,175)	17	8
9	VACATION ACCRUAL	2,491	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,046)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(3,099)	0	0	0	0	0	0	0	0	0	0	(3,099)	1
2	Food Purchase	(1,240)	0	0	0	0	0	0	0	0	0	0	(1,240)	2
3	Housekeeping	(2,571)	0	0	0	0	0	0	0	0	0	0	(2,571)	3
4	Laundry	(1,708)	0	0	0	0	0	0	0	0	0	0	(1,708)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(422)	0	0	0	0	0	0	0	0	0	0	(422)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,040)	0	0	0	0	0	0	0	0	0	0	(9,040)	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	6,163	0	0	(49,606)	0	0	0	0	0	0	0	(43,443)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,725)	0	0	0	0	0	0	0	0	0	0	(1,725)	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	4,438	0	0	(49,606)	0	0	0	0	0	0	0	(45,168)	16
	C. General Administration													
17	Administrative	(4,175)	0	(409,649)	0	0	(136,550)	0	0	0	0	0	(550,374)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,050	(116,576)	1,232	(175,804)	0	0	0	0	0	0	(283,098)	19
20	Fees, Subscriptions & Promotions	(76,780)	0	248	246	342	0	0	0	0	0	0	(75,944)	20
21	Clerical & General Office Expenses	1,433	77	55,169	1,827	139,163	0	0	0	0	0	0	197,669	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	1,715	4,249	2,244	0	0	0	0	0	0	8,208	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	31,121	2,088	1,730	1,732	0	0	0	0	0	0	36,671	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(91,522)	39,248	(467,005)	9,284	(32,323)	(136,550)	0	0	0	0	0	(678,868)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(96,124)	39,248	(467,005)	(40,322)	(32,323)	(136,550)	0	0	0	0	0	(733,076)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(18,081)	270,316	0	0	0	0	0	0	0	0	0	252,235	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(127,103)	426,517	0	0	0	0	0	0	0	0	0	299,414	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(576,000)	0	1,028	32,139	0	0	0	0	0	0	(542,833)	34
35	Rent-Equipment & Vehicles	0	0	5,470	3,766	1,927	0	0	0	0	0	0	11,163	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(145,184)	120,833	5,470	4,794	34,066	0	0	0	0	0	0	19,979	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(241,308)	160,081	(461,535)	(35,528)	1,743	(136,550)	0	0	0	0	0	(713,097)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		MCKINLEY AVE, LLC		
					MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS ENTITIES		

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 576,000	MCKINLEY AVE, LLC		\$	(576,000)	1
2	V	19 ACCOUNTING FEES		" "		7,800	7,800	2
3	V	19 PROFESSIONAL FEES		" "		250	250	3
4	V	26 MORTGAGE INSURANCE		" "		31,121	31,121	4
5	V	30 DEPRECIATION-BLDG/IMP		" "		216,316	216,316	5
6	V	30 DEPRECIATION- EQPT		" "		54,000	54,000	6
7	V	32 AMORTIZATION - MTG COST		" "		4,347	4,347	7
8	V	32 INTEREST - MORTGAGE		" "		414,689	414,689	8
9	V	21 OFFICE EXPENSES		" "		77	77	9
10	V	32 INTEREST - OTHER		" "		7,481	7,481	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 576,000			\$ 736,081	\$ * 160,081	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 127,573	YORK MANAGEMENT ASSOCIATES, INC.		\$ 10,997	\$ (116,576)
16	V	20 DUES & SUBSCRIPTIONS		" "		248	248
17	V	21 CLERICAL		" "		55,169	55,169
18	V	24 TRAVEL		" "		1,715	1,715
19	V	26 INSURANCE		" "		2,088	2,088
20	V	35 RENT - EQPT & VEH		" "		5,470	5,470
21	V	17 ADMINISTRATIVE	409,649	" "			(409,649)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 537,222			\$ 75,687	\$ * (461,535)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 86,517	CARLYLE NURSING ASSOCIATES, LLC		\$ 36,911	\$ (49,606)
16	V	19 PROFESSIONAL FEES		"		1,232	1,232
17	V	20 DUES & SUBSCRIPTIONS		"		246	246
18	V	21 CLERICAL		"		1,827	1,827
19	V	24 TRAVEL		"		4,249	4,249
20	V	26 INSURANCE		"		1,730	1,730
21	V	30 DEPRECIATION		"			
22	V	34 RENT		"		1,028	1,028
23	V	35 RENT - EQPT & VEH		"		3,766	3,766
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 86,517			\$ 50,989	\$ * (35,528)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 179,936	THE KENSINGTON GROUP, LLC		\$ 4,132	\$ (175,804)
16	V	20 DUES & SUBSCRIPTIONS		"		342	342
17	V	21 CLERICAL		"		139,163	139,163
18	V	24 TRAVEL		"		2,244	2,244
19	V	26 INSURANCE		"		1,732	1,732
20	V	30 DEPRECIATION		"			
21	V	34 RENT		"		32,139	32,139
22	V	35 RENT - EQPT & VEH		"		1,927	1,927
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 179,936			\$ 181,679	\$ * 1,743

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$ 136,550	CHESTERFIELD, LLC		\$	\$ (136,550)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 136,550			\$ 0	\$ * (136,550)

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
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								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 **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

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 YORK MANAGEMENT ASSOC., LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	155,033	3	\$ 33,323	\$ 51,159	\$ 10,997	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	155,033	3	750	51,159	248	2
3	21	CLERICAL	PATIENT DAYS	155,033	3	167,179	161,657	55,169	3
4	24	TRAVEL	PATIENT DAYS	155,033	3	5,198	51,159	1,715	4
5	26	INSURANCE	PATIENT DAYS	155,033	3	6,327	51,159	2,088	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	155,033	3	16,576	51,159	5,470	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					\$ 229,353	\$ 161,657	\$ 75,687	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

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 CARLYLE NURSING ASSOCIATES, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 36,911	\$ 36,911	1	\$ 36,911	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	11,646		51,159	1,232	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	2,323		51,159	246	3
4	21	CLERICAL	PATIENT DAYS	483,650	17,276		51,159	1,827	4
5	24	TRAVEL	PATIENT DAYS	483,650	40,167		51,159	4,249	5
6	26	INSURANCE	PATIENT DAYS	483,650	16,351		51,159	1,730	6
7	30	DEPRECIATION	PATIENT DAYS	483,650			51,159		7
8	34	RENT	PATIENT DAYS	483,650	9,715		51,159	1,028	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	35,603		51,159	3,766	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				\$ 169,992	\$ 36,911		\$ 50,989	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

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

Name of Related Organization THE KENSINGTON GROUP, LLC
 Street Address 8140 RIVER DRIVE
 City / State / Zip Code MORTON GROVE, IL 60053
 Phone Number (847) 583-0100
 Fax Number (847) 583-8873

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	\$ 39,055	\$ 51,159	\$ 4,132	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234	51,159	342	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	51,159	139,163	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213	51,159	2,244	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374	51,159	1,732	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9		51,159		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769	51,159	32,139	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	483,650	9	18,215	51,159	1,927	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					\$ 1,717,200	\$ 1,150,879	\$ 181,679	25

Facility Name & ID Number

MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	Name of Lender	2		3	4	5	6		7	8	9	10
		Related**					Purpose of Loan	Monthly Payment Required				
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - MCKINLEY AVE, LLC						\$	\$			\$	1
2	GMAC MORTGAGE CORP.		X	MORTGAGE	\$39,218.00	07/2002	6,375,000	6,198,912	07/2037	6.6600	414,689	2
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	136,255			4,347	3
4												4
5												5
	Working Capital											
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	2,852,124	DEMAND	VARIES	152,970	6
7	LETTER OF CREDIT FEE		X								2,831	7
8												8
9	TOTAL Facility Related				\$39,218.00		\$ 7,002,161	\$ 9,187,291			\$ 574,837	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 7,002,161	\$ 9,187,291			\$ 574,837	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2004 report.		\$	76,176	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.)		\$	77,987	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,811	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	78,840	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.		\$	80,651	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	31,866	8
	2001	64,976	9
	2002	69,633	10
	2003	75,347	11
	2004	77,987	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-12-03-251-015</u>	<u>NURSING HOME</u>	\$ <u>77,987.34</u>	\$ <u>77,987.34</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>77,987.34</u>	\$ <u>77,987.34</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? (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? (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>119,700</u>	<u>1997</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	119,700		\$	3

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	1997		\$ 4,688,282	\$ 170,483	27.5	\$ 170,483	\$	\$ 1,356,760	4
5		1997		10,762	391	27.5	391		2,919	5
6		1998		95,000	3,455	27.5	3,455		24,039	6
7										7
8										8
	Improvement Type**									
9	RELATED PARTY - MCKINLEY AVE, LLC									
10	OUTDOOR SIGNS									
11	REPLACE, REPAIR AND SEAL PAVEMENT									
12	REPLACE BLACK VALLEYS									
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS									
14	SPRINKLER SYSTEMS									
15	COURTYARD IMPROVEMENTS									
16	RESIDENT ROOMS/BATHROOMS - PAINTING									
17	FIRE ALARM CONTROL PANEL									
18	REMODELING - ARCHITECT FEE									
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATIONS									
20	REPLACED 2 YORK ROOFTOP HVAC UNITS									
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS									
22	STENCIL & COAT LANDING DOCK & WALKWAY									
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING									
24	PREPARE & RESURFACE NORTH PARKING LOT									
25	DRAPES, WALLCOVERINGS & BORDERS-SOUTH CORRIDOR & L									
26	PREP, PAINT, HANG WALLCOVERINGS & BORDERS-PATIENT &									
27	DRAPES, CURTAINS, BORDERS & SIGNS - LOBBY, BEAUTY SHOP									
28	BOARD FOR BEHIND THE HANDRAILS - FRONT LOBBY									
29	LIGHTING FIXTURES AROUND THE OUTSIDE OF THE BLDG									
30	DRAPES, VALANCE, RODS & HANDRAILS - PATIENT RMS									
31	OAK UNFINISHED CABINETS AND BAY WINDOW TREATMENTS									
32	PREP & PAINT 26 BATHROOMS AFTER WALLPAPER REMOVAL									
33	REMOVE & DISPOSE ROOF BEHIND AIR CONDITIONER									
34	LAMINATED COUNTERTOP & SOLID SURFACE COUNTERS									
35	FURNITURE STORAGE WHILE REMODELING									
36	WIDEN TURNING RADIUS;PAVE PARKING LOT AND									

*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 MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2004	\$ 15,150	\$ 1,439	15	\$ 1,010	\$ (429)	\$ 505	37
38	2004	82,244	20,223	7	11,749	(8,474)	5,732	38
39	2005	8,000	283	7	571	288		39
40	2005	11,720	71	27.5	71			40
41								41
42		ADJ TO SL	(21,673)			21,673		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								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)		\$ 5,308,326	\$ 216,316		\$ 216,316	\$ 1,447,792	70

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

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 578,850	\$ 62,715	\$ 52,310	\$ (10,405)	3-15 YRS	\$ 208,265	71
72	Current Year Purchases	51,172	10,235	2,559	(7,676)	3-15 YRS	2,559	72
73	Fully Depreciated Assets	12,990					12,990	73
74	RELATED PARTIES		54,000	54,000				74
75	TOTALS	\$ 643,012	\$ 126,950	\$ 108,869	\$ (18,081)		\$ 223,814	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,951,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 343,266	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 325,185	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,081)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,671,606	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A - RELATED PARTY**

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: _____ *

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: \$ **16,050** Description: **SEE SCHEDULE ATTACHED**

(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	FACILITY USE	2002 DODGE PICKUP	\$ 281.46	\$ 281	17
18					18
19					19
20					20
21	TOTAL		\$ 281.46	\$ 281	21

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. _____ /2006 \$ _____

13. _____ /2007 \$ _____

14. _____ /2008 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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.)

	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	39-3	hrs	\$		\$ 154,436	\$		\$ 154,436	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			20,179			20,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			161,737			161,737	4
5	Physician Care		visits							5
6	Dental Care		visits			2,716			2,716	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				129,355		129,355	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS, LAB, I.V. THERAPY Other (specify): X-RAY	39-2					22,470		22,470	13
14	TOTAL			\$		\$ 339,068	\$ 151,825		\$ 490,893	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 MCKINLEY COURT

0042499

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,407	\$ 213,689	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,089,735	1,089,735	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,377	134,338	6
7	Other Prepaid Expenses	20,863	20,863	7
8	Accounts Receivable (owners or related parties)	348,554	11,351	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		909,308	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,509,936	\$ 2,379,284	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,123,251	3,123,251	11
12	Long-Term Investments			12
13	Land		841,622	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		510,820	15
16	Equipment, at Historical Cost	630,022	1,170,022	16
17	Accumulated Depreciation (book methods)	(513,618)	(2,755,196)	17
18	Deferred Charges		136,255	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,239,655	\$ 7,810,056	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,749,591	\$ 10,189,340	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 335,653	\$ 335,653	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,048	44,048	28
29	Short-Term Notes Payable	34,964	34,964	29
30	Accrued Salaries Payable	56,524	56,524	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,779	10,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)		78,840	32
33	Accrued Interest Payable		34,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>MANAGEMENT FEES</u>	11,504	11,504	36
37	<u>DUE TO DPA</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 493,472	\$ 606,716	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,655,597	1,044,028	39
40	Mortgage Payable		6,198,912	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,655,597	\$ 7,242,940	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,149,069	\$ 7,849,656	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,600,522	\$ 2,339,684	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,749,591	\$ 10,189,340	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,713,998	1
2	Restatements (describe):		2
3			3
4	2004 REPLACEMENT TAX	(1,953)	4
5	ROUNDING ADJ.	3	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,712,048	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(111,526)	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)	\$ (111,526)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,600,522	24 *

* This must agree with page 17, line 47.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,760,798	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,760,798	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	127,103	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 127,103	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	2,187	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,187	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,890,088	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,170,142	31
32	Health Care	2,272,807	32
33	General Administration	2,086,490	33
	B. Capital Expense		
34	Ownership	899,157	34
	C. Ancillary Expense		
35	Special Cost Centers	490,893	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,001,614	40
41	Income before Income Taxes (line 30 minus line 40)**	(111,526)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (111,526)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 **MCKINLEY COURT**

0042499

Report Period Beginning: **01/01/2005**

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,931	2,120	\$ 63,259	\$ 29.84	1
2	Assistant Director of Nursing	1,353	1,710	55,157	32.26	2
3	Registered Nurses	13,619	14,896	299,635	20.12	3
4	Licensed Practical Nurses	31,225	33,536	564,828	16.84	4
5	CNAs & Orderlies	72,836	78,635	752,443	9.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,429	6,420	89,076	13.87	8
9	Activity Director	3,725	4,128	69,900	16.93	9
10	Activity Assistants	5,555	5,967	45,882	7.69	10
11	Social Service Workers	1,796	2,171	25,443	11.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	12,854	14,064	143,642	10.21	14
15	Cook Helpers/Assistants	11,975	12,269	86,020	7.01	15
16	Dishwashers					16
17	Maintenance Workers	4,566	5,053	82,053	16.24	17
18	Housekeepers	19,725	21,598	202,837	9.39	18
19	Laundry	14,459	15,352	115,791	7.54	19
20	Administrator	2,162	2,243	72,514	32.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,081	10,716	160,033	14.93	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	3,592	3,904	48,363	12.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,883	234,782	\$ 2,876,876 *	\$ 12.25	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	200	\$ 10,431	1-3	35
36	Medical Director	120	36,000	9-3	36
37	Medical Records Consultant	12	1,200	10-3	37
38	Nurse Consultant	738	86,517	10-3	38
39	Pharmacist Consultant	216	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	56	3,244	11-3	44
45	Social Service Consultant	52	3,036	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,394	\$ 141,628		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0	10-3	50
51	Licensed Practical Nurses	0	10-3	51
52	Certified Nurse Assistants/Aides	0	10-3	52
53	TOTAL (lines 50 - 52)	\$		53

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							
																	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	06/2002	\$ 2,840	3	\$ 473	\$ 947	\$ 947	\$ 473	\$	\$	\$	\$												
2	PAINT/DECORATING	06/2003	9,437	3		1,572	3,146	3,146	1,573															
3	PAINT/DECORATING	06/2004	4,105	3			684	1,368	1,368	685														
4	PAINT/DECORATING	06/2005	4,800	3				800	1,600	1,600	800													
5																								
6																								
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18																								
19																								
20	TOTALS		\$ 21,182		\$ 473	\$ 2,519	\$ 4,777	\$ 5,787	\$ 4,541	\$ 2,285	\$ 800	\$												

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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. ILL. HEALTHCARE ASSOC. - \$9000
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,359 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (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. \$ 82,125
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? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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