

Facility Name & ID Number MCKINLEY COURT

0042499 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	781	443	10,741	11,965	8
9	SNF/PED					9
10	ICF	23,676	13,431		37,107	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,457	13,874	10,741	49,072	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.63%

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 10,540

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number

MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	267,604	61,851	10,741	340,196		340,196	(123)	340,073		1
2	Food Purchase		240,798		240,798		240,798	(2,373)	238,425		2
3	Housekeeping	210,132	40,994		251,126		251,126	(1,613)	249,513		3
4	Laundry	145,989	27,882		173,871		173,871	(617)	173,254		4
5	Heat and Other Utilities			138,974	138,974		138,974		138,974		5
6	Maintenance	119,335	24,557	38,002	181,894		181,894	4,632	186,526		6
7	Other (specify):*			21,134	21,134		21,134		21,134		7
8	TOTAL General Services	743,060	396,082	208,851	1,347,993		1,347,993	(94)	1,347,899		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,782,288	147,294	89,817	2,019,399		2,019,399	(32,636)	1,986,763		10
10a	Therapy	122,481			122,481		122,481		122,481		10a
11	Activities	139,958	11,363	12,390	163,711		163,711	(1,753)	161,958		11
12	Social Services	44,867		2,646	47,513		47,513		47,513		12
13	CNA Training										13
14	Program Transportation			50	50		50		50		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,089,594	158,657	134,903	2,383,154		2,383,154	(34,389)	2,348,765		16
	C. General Administration										
17	Administrative	98,750		622,255	721,005		721,005	(616,816)	104,189		17
18	Directors Fees										18
19	Professional Services			461,209	461,209		461,209	(274,560)	186,649		19
20	Dues, Fees, Subscriptions & Promotions			133,275	133,275		133,275	(98,546)	34,729		20
21	Clerical & General Office Expenses	283,375	32,912	71,700	387,987		387,987	150,369	538,356		21
22	Employee Benefits & Payroll Taxes			644,376	644,376		644,376		644,376		22
23	Inservice Training & Education			3,931	3,931		3,931		3,931		23
24	Travel and Seminar			1,595	1,595		1,595	11,043	12,638		24
25	Other Admin. Staff Transportation			10,589	10,589		10,589		10,589		25
26	Insurance-Prop.Liab.Malpractice			111,713	111,713		111,713	6,138	117,851		26
27	Other (specify):*			75,319	75,319		75,319	(75,319)			27
28	TOTAL General Administration	382,125	32,912	2,135,962	2,550,999		2,550,999	(897,691)	1,653,308		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,214,779	587,651	2,479,716	6,282,146		6,282,146	(932,174)	5,349,972		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	10,741
	REPAIRS & MAINTENANCE	0
		0
		10,741
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	39,539
	ELECTRICITY	89,809
	WATER	9,626
	CABLE TV - LOBBY	0
		0
		138,974
6	MAINTENANCE	
	GROUNDS MAINTENANCE	9,296
	PAINTING & DECORATING	689
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,263
	ELEVATOR MAINTENANCE & REPAIR	2,642
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	5,124
	FIRE SERVICE	7,988
		0
		0
		0
		0
		38,002
7	OTHER	
	SCAVENGER	21,134
	SECURITY SERVICE	0
		0
		0
		21,134
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

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	2,100
	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
		89,817
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	9,744
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,646
		0
		12,390
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,646
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,646
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	50
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	622,255
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	33,816
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	427,393
		0
		461,209
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	41,069
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	50,894
	EMPLOYEE WANT ADS XIX F	4,608
	CONTRIBUTIONS VI 20 XIX F	809
	DUES & SUBSCRIPTIONS XIX F	23,477
	LICENSES & PERMITS XIX F	2,905
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,613
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	900
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,230
	PATIENT BACKGROUND CHECKS XIX F	1,770
		133,275
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,195
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	10,935
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	51,323
	MESSENGER SERVICE	5,247
		0
		71,700

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	238,205
	UNEMPLOYMENT COMPENSATION XIX D	74,451
	WORKERS COMPENSATION INSURANC XIX D	72,159
	HOSPITALIZATION INSURANCE XIX D	231,357
	EMPLOYEE BENEFITS - OTHER XIX D	15,411
	EMPLOYEE PHYSICAL EXAMS XIX D	3,775
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,018
	CHICAGO HEAD TAX XIX D	0
		0
		644,376
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	3,931
		3,931
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,595
		1,595
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	10,589
		10,589
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	111,713
		111,713
27	OTHER	
	BAD DEBTS VI 24	75,319
		75,319

GRAND TOTAL COLUMN 3 OTHER

2,479,716

**MCKINLEY COURT
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	240,798
LESS SALES TAX	<u>(2,373)</u>
NET FOOD	238,425

TOTAL PATIENT CENSUS	49,072
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	147,216

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	147,216
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	147,216

NET FOOD	238,425
DIVIDE TOTAL MEALS/YEAR	<u>147,216</u>

COST PER MEAL	1.62
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

MCKINLEY COURT

#0042499

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			47,853	47,853		47,853	240,755	288,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			250,931	250,931		250,931	276,883	527,814			32
33	Real Estate Taxes			84,307	84,307		84,307		84,307			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(539,022)	36,978			34
35	Rent-Equipment & Vehicles			22,468	22,468		22,468	9,143	31,611			35
36	Other (specify):* STORAGE/MTG INS			5,393	5,393		5,393	30,523	35,916			36
37	TOTAL Ownership			986,952	986,952		986,952	18,282	1,005,234			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		328,961	496,183	825,144		825,144		825,144			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		328,961	578,308	907,269		907,269		907,269			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,214,779	916,612	4,044,976	8,176,367		8,176,367	(913,892)	7,262,475			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	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	11,941	30		9
10	Interest and Other Investment Income	(142,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,373)	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	(10,935)	21		18
19	Entertainment	(41,069)	20		19
20	Contributions	(1,709)	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	(75,319)	27		24
25	Fund Raising, Advertising and Promotional	(50,894)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,613)	20		28
29	Other-Attach Schedule	6,099			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (312,289)		\$	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	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)	(601,603)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (601,603)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (913,892)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,973	6	1
2	VACATION ACCRUAL	(123)	1	2
3	VACATION ACCRUAL	(1,613)	3	3
4	VACATION ACCRUAL	(617)	4	4
5	VACATION ACCRUAL	1,659	6	5
6	VACATION ACCRUAL	9,821	10	6
7	VACATION ACCRUAL	(1,753)	11	7
8	VACATION ACCRUAL	5,439	17	8
9	VACATION ACCRUAL	(1,200)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(378)	19	11
12	MARKETING CONSULATNT	(6,109)	19	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	6,099		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(123)	0	0	0	0	0	0	0	0	0	0	(123)	1
2	Food Purchase	(2,373)	0	0	0	0	0	0	0	0	0	0	(2,373)	2
3	Housekeeping	(1,613)	0	0	0	0	0	0	0	0	0	0	(1,613)	3
4	Laundry	(617)	0	0	0	0	0	0	0	0	0	0	(617)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,632	0	0	0	0	0	0	0	0	0	0	4,632	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(94)	0	0	0	0	0	0	0	0	0	0	(94)	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	9,821	0	0	(42,457)	0	0	0	0	0	0	0	(32,636)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,753)	0	0	0	0	0	0	0	0	0	0	(1,753)	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	8,068	0	0	(42,457)	0	0	0	0	0	0	0	(34,389)	16
	C. General Administration													
17	Administrative	5,439	0	(466,691)	0	0	(155,564)	0	0	0	0	0	(616,816)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,487)	9,564	(4,973)	717	(271,381)	0	0	0	0	0	0	(274,560)	19
20	Fees, Subscriptions & Promotions	(99,285)	0	199	106	434	0	0	0	0	0	0	(98,546)	20
21	Clerical & General Office Expenses	(12,135)	0	1,294	1,201	160,009	0	0	0	0	0	0	150,369	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	4,967	2,876	3,200	0	0	0	0	0	0	11,043	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	1,719	1,897	2,522	0	0	0	0	0	0	6,138	26
27	Other (specify):*	(75,319)	0	0	0	0	0	0	0	0	0	0	(75,319)	27
28	TOTAL General Administration	(189,787)	9,564	(463,485)	6,797	(105,216)	(155,564)	0	0	0	0	0	(897,691)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(181,813)	9,564	(463,485)	(35,660)	(105,216)	(155,564)	0	0	0	0	0	(932,174)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	11,941	224,854	186	182	3,592	0	0	0	0	0	0	240,755	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(142,417)	419,300	0	0	0	0	0	0	0	0	0	276,883	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	1,464	35,514	0	0	0	0	0	0	(539,022)	34
35	Rent-Equipment & Vehicles	0	0	4,032	2,956	2,155	0	0	0	0	0	0	9,143	35
36	Other (specify):*	0	30,523	0	0	0	0	0	0	0	0	0	30,523	36
37	TOTAL Ownership	(130,476)	98,677	4,218	4,602	41,261	0	0	0	0	0	0	18,282	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)	(312,289)	108,241	(459,267)	(31,058)	(63,955)	(155,564)	0	0	0	0	0	(913,892)	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	36 MORTGAGE INSURANCE		" "		30,523	30,523	2
3	V	30 DEPRECIATION - BLD/IMP		" "		220,354	220,354	3
4	V	30 DEPRECIATION - EQPT		" "		4,500	4,500	4
5	V	32 AMORTIZATION-MTG COST		" "		4,347	4,347	5
6	V	32 INTEREST-MORTGAGE		" "		406,728	406,728	6
7	V	32 INTEREST - OTHER		" "		8,225	8,225	7
8	V	19 ACCOUNTING FEES				9,364	9,364	8
9	V	19 DATA PROCESSING				200	200	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 576,000			\$ 684,241	\$ * 108,241	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	\$ 42,306	YORK MANAGEMENT ASSOCIATION, INC.		\$ 37,333	\$ (4,973)
16	V	20 DUES & SUBSCRIPTIONS		"		199	199
17	V	21 CLERICAL		"		1,294	1,294
18	V	24 TRAVEL		"		4,967	4,967
19	V	26 INSURANCE		"		1,719	1,719
20	V	35 RENT - EQPT & VEH		"		4,032	4,032
21	V	17 ADMINISTRATION	466,691	"			(466,691)
22	V	30 DEPRECIATION		"		186	186
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		\$ 508,997			\$ 49,730	\$ * (459,267)

* 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		\$ 44,060	\$ (42,457)
16	V	19 PROFESSIONAL FEES		"		717	717
17	V	20 DUES & SUBSCRIPTIONS		"		106	106
18	V	21 CLERICAL		"		1,201	1,201
19	V	24 TRAVEL		"		2,876	2,876
20	V	26 INSURANCE		"		1,897	1,897
21	V	30 DEPRECIATION		"		182	182
22	V	34 RENT		"		1,464	1,464
23	V	35 RENT - EQPT & VEH		"		2,956	2,956
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			\$ 55,459	\$ * (31,058)

* 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	\$ 275,128	THE KENSINGTON GROUP, LLC		\$ 3,747	\$ (271,381)
16	V	20 DUES & SUBSCRIPTIONS		"		434	434
17	V	21 CLERICAL		"		160,009	160,009
18	V	24 TRAVEL		"		3,200	3,200
19	V	26 INSURANCE		"		2,522	2,522
20	V	30 DEPRECIATION		"		3,592	3,592
21	V	34 RENT		"		35,514	35,514
22	V	35 RENT - EQPT & VEH		"		2,155	2,155
23	V	17 ADMINISTRATIVE		"			
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		\$ 275,128			\$ 211,173	\$ * (63,955)

* 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	\$ 155,564	CHESTERFIELD, LLC		\$	\$ (155,564)	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		\$ 155,564			\$	0	\$ * (155,564) 39

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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: **01/01/2007** Ending: **2/31/2007**

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. LTD
 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	19	PROFESSIONAL FEES	PATIENT DAYS	184,515	\$ 140,375	\$	49,072	\$ 37,333	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	184,515	750		49,072	199	2
3	21	CLERICAL	PATIENT DAYS	184,515	4,865		49,072	1,294	3
4	24	TRAVEL	PATIENT DAYS	184,515	18,678		49,072	4,967	4
5	26	INSURANCE	PATIENT DAYS	184,515	6,463		49,072	1,719	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	184,515	15,160		49,072	4,032	6
7	21	CLERICAL	DIRECT HOURS				1		7
8	30	DEPRECIATION	PATIENT DAYS	184,515	701		49,072	186	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				\$ 186,992	\$		\$ 49,730	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

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 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	10	NURSING	DIRECT HOURS	1	\$ 44,060	\$ 44,060	1	\$ 44,060	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	8,078	49,072	717	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	1,197	49,072	106	3
4	21	CLERICAL	PATIENT DAYS	553,355	11	13,541	49,072	1,201	4
5	24	TRAVEL	PATIENT DAYS	553,355	11	32,426	49,072	2,876	5
6	26	INSURANCE	PATIENT DAYS	553,355	11	21,389	49,072	1,897	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	11	2,056	49,072	182	7
8	34	RENT	PATIENT DAYS	553,355	11	16,500	49,072	1,464	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	33,327	49,072	2,956	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				\$ 172,574	\$ 44,060		\$ 55,459	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2007** Ending: **2/31/2007**

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 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

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	PROFESIONAL FEES	PATIENT DAYS	553,355	11	\$ 42,255	\$ 49,072	\$ 3,747	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	49,072	434	2	
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	49,072	18,080	3	
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	49,072	3,200	4	
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	49,072	2,522	5	
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	49,072	3,592	6	
7	34	RENT	PATIENT DAYS	553,355	11	400,473	49,072	35,514	7	
8	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	11	24,297	49,072	2,155	8	
9									9	
10	21	CLERICAL	DIRECT HOURS	1	1	141,929	141,929	1	141,929	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					\$ 922,750	\$ 141,929	\$ 211,173	25	

Facility Name & ID Number

MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		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		6,375,000	6,075,697	07/2037	6.6600	406,728	2						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	127,560			4,347	3						
4												4						
5												5						
Working Capital																		
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	4,097,942	DEMAND	VARIES	258,319	6						
7	LETTER OF CREDIT FEE		X								837	7						
8												8						
9	TOTAL Facility Related				\$39,218.00		\$ 7,002,161	\$ 10,301,199			\$ 670,231	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	\$ 10,301,199			\$ 670,231	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 2006 report.	\$	82,340	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.)	\$	82,847	2
3. Under or (over) accrual (line 2 minus line 1).	\$	507	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	83,800	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.	\$	84,307	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	69,633	8
	2003	75,347	9
	2004	77,987	10
	2005	81,438	11
	2006	82,847	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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 2006 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 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 2006 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 2006.

(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>82,847.26</u>	\$ <u>82,847.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>82,847.26</u>	\$ <u>82,847.26</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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).

N/A

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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:

01/01/2007 Ending: 12/31/2007

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 BHF 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	\$	\$ 1,868,209	4
5		1997		10,762	391	27.5	391		4,092	5
6		1998		95,000	3,455	27.5	3,455		34,404	6
7										7
8										8
	Improvement Type**									
9	RELATED PARTY - MCKINLEY AVE, LLC									
10		1997		13,284	483	27.5	483		5,051	9
11		1998		6,754	399	15	450	51	4,275	10
12		1999		5,875	214	27.5	214		1,809	11
13		1999		154,975	5,635	27.5	5,635		47,664	12
14		1999		4,744	173	27.5	173		1,462	13
15		1999		5,975	353	15	398	45	3,383	14
16		2000		13,710	498	27.5	498		3,716	15
17		2000		6,703	244	27.5	244		1,819	16
18		2000		1,493	88	15	100	12	750	17
19		2001		7,382	268	27.5	268		1,731	18
20		2003		11,340	412	27.5	412		1,837	19
21		2003		19,732	718	27.5	718		3,201	20
22		2003		4,397	160	27.5	160		713	21
23		2003		2,000	73	27.5	73		326	22
24		2003		5,120	186	27.5	186		826	23
25		2004		21,455	2,681	7	3,065	384	10,728	24
26		2004		58,800	7,347	7	8,400	1,053	29,400	25
27		2004		14,052	1,756	7	2,007	251	7,025	26
28		2004		1,585	58	27.5	58		210	27
29		2004		3,335	121	27.5	121		439	28
30		2004		12,350	1,543	7	1,764	221	6,174	29
31		2004		1,578	197	7	225	28	788	30
32		2004		3,800	475	7	543	68	1,900	31
33		2004		3,000	375	7	429	54	1,501	32
34		2004		8,300	1,037	7	1,186	149	4,151	33
35		2004		5,429	678	7	776	98	2,716	34
36										35
										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 MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALL SPEED BUMPS	2004	\$ 15,150	\$ 1,166	15	\$ 1,010	\$ (156)	\$ 3,535	37
38	INSTALL VINYL SHEET FLOORING - CARPET HALLS	2004	82,244	10,318	7	11,749	1,431	40,979	38
39	PAINT AND PATCH 30 PATIENT ROOMS	2005	8,000	1,573	7	1,143	(430)	2,857	39
40	TWO ROOF TOP UNITS	2005	11,720	426	27.5	426		923	40
41	REPLACEMENT WINDOWS	2006	958	35	27.5	35		54	41
42	2 NEW ROOFTOP UNITS	2006	12,994	473	27.5	473		611	42
43	2 ASSISTANT SHOWER ROOMS	2006	8,880	323	27.5	323		363	43
44	TILES - NORTH NURSE'S STATION	2007	4,079	148	27.5	148		148	44
45	FLOOR MATERIALS FOR SOUTH NURSE'S STATION	2007	8,241	300	27.5	300		300	45
46	FIRE ALARM PANEL	2007	2,981	99	27.5	99		99	46
47	REMODEL EAST NURSES STATION	2007	6,925	231	27.5	231		231	47
48	INSTALL 4 THRESHOLDS FOR SOUTH CRDR-NURSES STA	2007	1,119	34	27.5	34		34	48
49	ROOF REPAIRS	2007	6,200	132	27.5	132		132	49
50	CUBICLE CURTAINS	2007	10,513	409	27.5	409		409	50
51	85 GALLON WATER HEATER AND COOLER DOOR	2007	10,769	228	27.5	228		228	51
52	CARPET FOR ADMINISTRATIVE OFFICE	2007	1,060	35	10	35		35	52
53	SEALING AND ASPHALT - ENTIRE PARKING LOT	2007	19,930	664	10	664		664	53
54									54
55			ADJ. TO SL	3,259			(3,259)		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)		\$ 5,402,975	\$ 220,354		\$ 220,354	\$	\$ 2,101,902	70

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

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	\$ 645,560	\$ 39,069	\$ 57,598	\$ 18,529		\$ 307,261	71
72	Current Year Purchases	43,922	8,784	2,196	(6,588)		2,196	72
73	Fully Depreciated Assets	19,123					19,123	73
74	RELATED PARTY	540,000	8,460	8,460			540,000	74
75	TOTALS	\$ 1,248,605	\$ 56,313	\$ 68,254	\$ 11,941		\$ 868,580	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)	\$ 6,651,580	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 276,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 288,608	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,941	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,970,482	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	PHYSICAL TPY ROOM	\$	92
93	& OFFICE SPACE RENOVATION	7,650	93
94			94
95		\$ 7,650	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: \$ 22,468 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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	\$		\$ 204,286	\$		\$ 204,286	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			39,294			39,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			249,671			249,671	4
5	Physician Care	39-3	visits			210			210	5
6	Dental Care	39-3	visits			2,722			2,722	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				250,783		250,783	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					78,178		78,178	13
14	TOTAL			\$		\$ 496,183	\$ 328,961		\$ 825,144	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 172,315	\$ 390,950	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,181)	2,007,262	2,007,262	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,794	97,864	6
7	Other Prepaid Expenses	19,343	19,343	7
8	Accounts Receivable (owners or related parties)	506,214	10,000	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		1,042,713	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,738,928	\$ 3,568,132	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,393,494	3,393,494	11
12	Long-Term Investments	1,351	1,351	12
13	Land		827,400	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		619,692	15
16	Equipment, at Historical Cost	708,606	1,248,606	16
17	Accumulated Depreciation (book methods)	(620,696)	(3,304,849)	17
18	Deferred Charges		127,560	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): <u>CONST. IN PROGRESS</u>		7,650	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,482,755	\$ 7,704,186	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,221,683	\$ 11,272,318	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 915,103	\$ 915,103	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	114,294	114,294	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,461	79,461	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,684	19,684	31
32	Accrued Real Estate Taxes(Sch.IX-B)		83,800	32
33	Accrued Interest Payable		33,720	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO DPA</u>	61,736	61,736	36
37	<u>MANAGEMENT FEES</u>	124,318	124,318	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,314,596	\$ 1,432,116	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,920,312	2,005,267	39
40	Mortgage Payable		6,075,697	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)	\$ 3,920,312	\$ 8,080,964	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,234,908	\$ 9,513,080	46
47	TOTAL EQUITY(page 18, line 24)	\$ 986,775	\$ 1,759,238	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,221,683	\$ 11,272,318	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 960,026	1
2	Restatements (describe):		2
3	rounding adj.	(5)	3
4	1065 REFUND	1,125	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 961,146	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,629	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)	\$ 25,629	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)	\$ 986,775	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	\$ 8,056,887	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,056,887	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	918	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)	\$ 918	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	142,417	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 142,417	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,774	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,774	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,201,996	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,347,993	31
32	Health Care	2,383,154	32
33	General Administration	2,550,999	33
	B. Capital Expense		
34	Ownership	986,952	34
	C. Ancillary Expense		
35	Special Cost Centers	825,144	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,176,367	40
41	Income before Income Taxes (line 30 minus line 40)**	25,629	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 25,629	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: **01/01/2007**

Ending:

12/31/2007

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	555	594	\$ 19,814	\$ 33.36	1
2	Assistant Director of Nursing	2,230	2,391	54,146	22.65	2
3	Registered Nurses	7,118	7,766	148,911	19.17	3
4	Licensed Practical Nurses	36,070	38,981	767,884	19.70	4
5	CNAs & Orderlies	66,886	72,421	723,878	10.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,984	7,652	122,481	16.01	8
9	Activity Director	3,903	4,342	78,277	18.03	9
10	Activity Assistants	6,581	7,204	61,681	8.56	10
11	Social Service Workers	4,042	4,507	44,867	9.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	14,519	16,028	161,196	10.06	14
15	Cook Helpers/Assistants	13,693	14,036	106,408	7.58	15
16	Dishwashers					16
17	Maintenance Workers	6,086	7,096	119,335	16.82	17
18	Housekeepers	19,754	21,594	210,132	9.73	18
19	Laundry	16,929	18,163	145,989	8.04	19
20	Administrator	2,045	2,520	98,750	39.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,199	15,329	283,375	18.49	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	4,899	5,389	67,655	12.55	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	226,493	246,013	\$ 3,214,779 *	\$ 13.07	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	199	\$ 10,741	1-3	35
36	Medical Director	96	30,000	9-3	36
37	Medical Records Consultant	18	2,100	10-3	37
38	Nurse Consultant	504	86,517	10-3	38
39	Pharmacist Consultant	96	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	44	2,646	11-3	44
45	Social Service Consultant	44	2,646	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,001	\$ 135,850		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LESLEY BLAKEMAN	ADMINISTRATOR		\$ 89,230	Workers' Compensation Insurance	\$ 72,159	IDPH License Fee	\$	
CHUCK JORDAN	ADMINISTRATOR		9,520	Unemployment Compensation Insurance	74,451	Advertising: Employee Recruitment	4,608	
	OTHER ADMIN		0	FICA Taxes	238,205	Health Care Worker Background Check	1,230	
				Employee Health Insurance	231,357	(Indicate # of checks performed <u>123</u>)		
				Employee Meals	0	Patient Background Checks	<u>177</u> 1,770	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	1,709	
				EMPLOYEE BENEFITS - OTHER	15,411	MARKETING/ADV/PROMO	97,576	
				EMPLOYEE PHYSICAL EXAMS	3,775	LICENSES/DUES/SUBSCRIPTIONS	26,382	
				PENSION/PROFIT SHARING PLANS	9,018	MGMT CO ALLOC	739	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(1,709)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(41,069)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(50,894)	
						Yellow page advertising	(5,613)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,750	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
YORK ASSOCIATES, LLC	MANAGEMENT FEES		\$ 466,691					
CHESTERFILED, LLC	MANAGEMENT FEES		155,564					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 622,255	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							TRAVEL	1,595
							RELATED PARTY	11,043
							Seminar Expense	
								0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
SEE SCHEDULE ATTACHED			461,209	TOTAL		\$	TOTAL	\$ 12,638
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 461,209					

* Attach copy of IMRF notifications

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2004	\$ 4,105	3	\$ 684	\$ 1,368	\$ 1,368	\$ 685	\$	\$	\$	\$								
2	PAINT/DECORATING	06/2005	4,805	3		800	1,600	1,600	800											
3	PAINT/DECORATING	06/2006	2,063	3			344	688	688	343										
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$ 10,973		\$ 684	\$ 2,168	\$ 3,312	\$ 2,973	\$ 1,488	\$ 343	\$	\$								

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. HEALTH CARE ASSOC. - \$9000; ILL COUNCIL ON LTC - \$8100
- (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. \$ 214 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees