

Facility Name & ID Number MCKINLEY COURT

0042499 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	54,900	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	54,900	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	808	437	11,466	12,711	8
9	SNF/PED					9
10	ICF	24,508	13,274	319	38,101	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,316	13,711	11,785	50,812	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.55%

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 11,466

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **MCKINLEY COURT** # **0042499** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	233,805	48,978	10,751	293,534		293,534	4,263	297,797		1
2	Food Purchase		269,249		269,249		269,249	(3,966)	265,283		2
3	Housekeeping	187,815	44,189		232,004		232,004	(2,808)	229,196		3
4	Laundry	151,397	44,757	118	196,272		196,272	(213)	196,059		4
5	Heat and Other Utilities			159,945	159,945		159,945		159,945		5
6	Maintenance	105,561	28,259	49,874	183,694		183,694	887	184,581		6
7	Other (specify):*			23,432	23,432		23,432		23,432		7
8	TOTAL General Services	678,578	435,432	244,120	1,358,130		1,358,130	(1,837)	1,356,293		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,049,944	183,952	89,927	2,323,823		2,323,823	(51,326)	2,272,497		10
10a	Therapy	51,738			51,738		51,738		51,738		10a
11	Activities	131,850	7,539	13,023	152,412		152,412	5,971	158,383		11
12	Social Services	40,841		3,266	44,107		44,107		44,107		12
13	CNA Training										13
14	Program Transportation			216	216		216		216		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,274,373	191,491	136,432	2,602,296		2,602,296	(45,355)	2,556,941		16
	C. General Administration										
17	Administrative	74,038		706,392	780,430		780,430	(712,095)	68,335		17
18	Directors Fees										18
19	Professional Services			432,894	432,894		432,894	(268,413)	164,481		19
20	Dues, Fees, Subscriptions & Promotions			128,082	128,082		128,082	(90,826)	37,256		20
21	Clerical & General Office Expenses	194,337	35,273	89,935	319,545		319,545	153,496	473,041		21
22	Employee Benefits & Payroll Taxes			578,167	578,167		578,167		578,167		22
23	Inservice Training & Education			5,789	5,789		5,789		5,789		23
24	Travel and Seminar			909	909		909	8,895	9,804		24
25	Other Admin. Staff Transportation			11,897	11,897		11,897		11,897		25
26	Insurance-Prop.Liab.Malpractice			122,317	122,317		122,317	16,568	138,885		26
27	Other (specify):*			981,998	981,998		981,998	(981,998)			27
28	TOTAL General Administration	268,375	35,273	3,058,380	3,362,028		3,362,028	(1,874,373)	1,487,655		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,221,326	662,196	3,438,932	7,322,454		7,322,454	(1,921,565)	5,400,889		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	10,751
	REPAIRS & MAINTENANCE	0
		0
		10,751
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	118
		0
		118
5	HEAT & OTHER UTILITIES	
	GAS HEAT	53,395
	ELECTRICITY	96,616
	WATER	9,934
	CABLE TV - LOBBY	0
		0
		159,945
6	MAINTENANCE	
	GROUNDS MAINTENANCE	12,718
	PAINTING & DECORATING	2,390
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	17,915
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,290
	FIRE SERVICE	12,561
		0
		0
		0
		0
		49,874
7	OTHER	
	SCAVENGER	23,432
	SECURITY SERVICE	0
		0
		0
		23,432
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	2,210
	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
		89,927
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	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	9,757
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,266
		0
		13,023
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,266
	SOCIAL WORKER XVIII B 45-2	0
		0
		3,266
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	216
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	706,392
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	26,402
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	406,492
		0
		432,894
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	58,207
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	20,451
	EMPLOYEE WANT ADS XIX F	11,485
	CONTRIBUTIONS VI 20 XIX F	895
	DUES & SUBSCRIPTIONS XIX F	20,729
	LICENSES & PERMITS XIX F	1,445
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	6,791
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,042
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,547
	PATIENT BACKGROUND CHECKS XIX F	1,490
		128,082
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	3,914
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	26,020
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	5,244
	TELEPHONE	48,803
	MESSENGER SERVICE	5,954
		0
		89,935

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	239,204
	UNEMPLOYMENT COMPENSATION XIX D	87,024
	WORKERS COMPENSATION INSURANC XIX D	65,362
	HOSPITALIZATION INSURANCE XIX D	159,898
	EMPLOYEE BENEFITS - OTHER XIX D	10,380
	EMPLOYEE PHYSICAL EXAMS XIX D	4,180
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	12,119
	CHICAGO HEAD TAX XIX D	0
		0
		578,167
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	5,789
		5,789
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	909
		909
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	11,897
		11,897
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	122,317
		122,317
27	OTHER	
	BAD DEBTS VI 24	981,998
		981,998

GRAND TOTAL COLUMN 3 OTHER

3,438,932

**MCKINLEY COURT
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	269,249
LESS SALES TAX	<u>(3,966)</u>
NET FOOD	265,283

TOTAL PATIENT CENSUS	50,812
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	152,436

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	152,436
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	152,436

NET FOOD	265,283
DIVIDE TOTAL MEALS/YEAR	<u>152,436</u>

COST PER MEAL	1.74
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number MCKINLEY COURT

#0042499

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			70,735	70,735		70,735	224,160	294,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			276,616	276,616		276,616	369,867	646,483			32
33	Real Estate Taxes			89,156	89,156		89,156		89,156			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(541,563)	34,437			34
35	Rent-Equipment & Vehicles			35,423	35,423		35,423	7,490	42,913			35
36	Other (specify):* STORAGE/MTG INS			6,428	6,428		6,428	30,193	36,621			36
37	TOTAL Ownership			1,054,358	1,054,358		1,054,358	90,147	1,144,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		330,889	566,990	897,879		897,879		897,879			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		330,889	649,340	980,229		980,229		980,229			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,221,326	993,085	5,142,630	9,357,041		9,357,041	(1,831,418)	7,525,623			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	(8,584)	30		9
10	Interest and Other Investment Income	(39,447)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,966)	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	(26,020)	21		18
19	Entertainment	(58,207)	20		19
20	Contributions	(5,937)	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	(981,998)	27		24
25	Fund Raising, Advertising and Promotional	(20,451)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,791)	20		28
29	Other-Attach Schedule	(4,710)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,156,111)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(675,307)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (675,307)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,831,418)		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (902)	6	1
2	VACATION ACCRUAL	4,263	1	2
3	VACATION ACCRUAL	(2,808)	3	3
4	VACATION ACCRUAL	(213)	4	4
5	VACATION ACCRUAL	1,789	6	5
6	VACATION ACCRUAL	1,659	10	6
7	VACATION ACCRUAL	5,971	11	7
8	VACATION ACCRUAL	(5,703)	17	8
9	VACATION ACCRUAL	(512)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(1,899)	19	11
12	MARKETING CONSULTANT	(4,355)	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	(4,710)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	4,263	0	0	0	0	0	0	0	0	0	0	4,263	1
2	Food Purchase	(3,966)	0	0	0	0	0	0	0	0	0	0	(3,966)	2
3	Housekeeping	(2,808)	0	0	0	0	0	0	0	0	0	0	(2,808)	3
4	Laundry	(213)	0	0	0	0	0	0	0	0	0	0	(213)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	887	0	0	0	0	0	0	0	0	0	0	887	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,837)	0	0	0	0	0	0	0	0	0	0	(1,837)	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	1,659	0	0	(52,985)	0	0	0	0	0	0	0	(51,326)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	5,971	0	0	0	0	0	0	0	0	0	0	5,971	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	7,630	0	0	(52,985)	0	0	0	0	0	0	0	(45,355)	16
	C. General Administration													
17	Administrative	(5,703)	0	(529,793)	0	0	(176,599)	0	0	0	0	0	(712,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,254)	10,443	(13,518)	68	(257,152)	0	0	0	0	0	0	(268,413)	19
20	Fees, Subscriptions & Promotions	(91,386)	0	82	142	336	0	0	0	0	0	0	(90,826)	20
21	Clerical & General Office Expenses	(26,532)	0	24,867	2,504	152,657	0	0	0	0	0	0	153,496	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	1,014	3,650	4,231	0	0	0	0	0	0	8,895	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	1,529	1,898	13,141	0	0	0	0	0	0	16,568	26
27	Other (specify):*	(981,998)	0	0	0	0	0	0	0	0	0	0	(981,998)	27
28	TOTAL General Administration	(1,113,873)	10,443	(515,819)	8,262	(86,787)	(176,599)	0	0	0	0	0	(1,874,373)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,108,080)	10,443	(515,819)	(44,723)	(86,787)	(176,599)	0	0	0	0	0	(1,921,565)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(8,584)	228,690	165	176	3,713	0	0	0	0	0	0	224,160	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(39,447)	409,314	0	0	0	0	0	0	0	0	0	369,867	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	0	34,437	0	0	0	0	0	0	(541,563)	34
35	Rent-Equipment & Vehicles	0	0	2,961	3,042	1,487	0	0	0	0	0	0	7,490	35
36	Other (specify):*	0	30,193	0	0	0	0	0	0	0	0	0	30,193	36
37	TOTAL Ownership	(48,031)	92,197	3,126	3,218	39,637	0	0	0	0	0	0	90,147	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)	(1,156,111)	102,640	(512,693)	(41,505)	(47,150)	(176,599)	0	0	0	0	0	(1,831,418)	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		" "		30,193	30,193	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		228,690	228,690	3
4	V	30 DEPRECIATION - EQPT		" "				4
5	V	32 AMORTIZATION - MTG COST		" "		4,347	4,347	5
6	V	32 INTEREST - MORTGAGE		" "		402,355	402,355	6
7	V	32 INTEREST - OTHER		" "		2,612	2,612	7
8	V	19 ACCOUNTING FEES		" "		10,229	10,229	8
9	V	19 DATA PROCESSING		" "		214	214	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 576,000			\$ 678,640	\$ * 102,640	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	\$ 56,408	YORK MANAGEMENT ASSOCIATION, LLC		\$ 42,890	\$ (13,518)
16	V	20 DUES & SUBSCRIPTIONS		"		82	82
17	V	21 CLERICAL		"		24,867	24,867
18	V	24 TRAVEL		"		1,014	1,014
19	V	26 INSURANCE		"		1,529	1,529
20	V	35 RENT - EQPT & VEH		"		2,961	2,961
21	V	17 ADMINISTRATION	529,793	"			(529,793)
22	V	30 DEPRECIATION		"		165	165
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		\$ 586,201			\$ 73,508	\$ * (512,693)

* 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		\$ 33,532	\$ (52,985)
16	V	19 PROFESSIONAL FEES		"		68	68
17	V	20 DUES & SUBSCRIPTIONS		"		142	142
18	V	21 CLERICAL		"		2,504	2,504
19	V	24 TRAVEL		"		3,650	3,650
20	V	26 INSURANCE		"		1,898	1,898
21	V	30 DEPRECIATION		"		176	176
22	V	34 RENT		"			
23	V	35 RENT - EQPT & VEH		"		3,042	3,042
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			\$ 45,012	\$ * (41,505)

* 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	\$ 269,904	THE KENSINGTON GROUP, LLC		\$ 12,752	\$ (257,152)
16	V	20 DUES & SUBSCRIPTIONS		"		336	336
17	V	21 CLERICAL		"		152,657	152,657
18	V	24 TRAVEL		"		4,231	4,231
19	V	26 INSURANCE		"		13,141	13,141
20	V	30 DEPRECIATION		"		3,713	3,713
21	V	34 RENT		"		34,437	34,437
22	V	35 RENT - EQPT & VEH		"		1,487	1,487
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		\$ 269,904			\$ 222,754	\$ * (47,150)

* 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	\$ 176,599	CHESTERFIELD, LLC		\$	\$ (176,599)
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		\$ 176,599			\$ 0	\$ * (176,599)

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

Facility Name & ID Number

MCKINLEY COURT

#

0042499

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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: **01/01/2008** Ending: **2/31/2008**

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 MANAGMEMENT 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	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	195,921	4	\$ 165,375	\$ 50,812	\$ 42,890	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	195,921	4	316	50,812	82	2
3	21	CLERICAL	PATIENT DAYS	195,921	4	4,912	50,812	1,274	3
4	24	TRAVEL	PATIENT DAYS	195,921	4	3,912	50,812	1,014	4
5	26	INSURANCE	PATIENT DAYS	195,921	4	5,896	50,812	1,529	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	195,921	4	11,418	50,812	2,961	6
7	21	CLERICAL	DIRECT HOURS	1	1	23,593	23,593	1	7
8	30	DEPRECIATION	PATIENT DAYS	195,921	4	635	50,812	165	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					\$ 216,057	\$ 23,593	\$ 73,508	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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	\$ 33,532	\$ 33,532	1	\$ 33,532	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	744	50,812	68	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	1,552	50,812	142	3
4	21	CLERICAL	PATIENT DAYS	554,294	11	27,317	50,812	2,504	4
5	24	TRAVEL	PATIENT DAYS	554,294	11	39,814	50,812	3,650	5
6	26	INSURANCE	PATIENT DAYS	554,294	11	20,700	50,812	1,898	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	11	1,923	50,812	176	7
8	34	RENT	PATIENT DAYS	554,294	11		50,812		8
9	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	33,179	50,812	3,042	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				\$ 158,761	\$ 33,532		\$ 45,012	25

Facility Name & ID Number **MCKINLEY COURT**

0042499 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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	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	554,294	11	\$ 139,104	\$ 50,812	\$ 12,752	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	50,812	336	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	50,812	16,689	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	50,812	4,231	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	50,812	13,141	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	50,812	3,713	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	50,812	34,437	7
8	35	RENT_EQPT & VEH	PATIENT DAYS	554,294	11	16,218	50,812	1,487	8
9	21	CLERICAL	DIRECT HOURS	1	1	135,968	135,968	1	135,968
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					\$ 1,082,673	\$ 135,968	\$ 222,754	25

Facility Name & ID Number

MCKINLEY COURT

0042499

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	CAPMARK		X	MORTGAGE	\$39,218.00		6,375,000	6,007,673	07/2037	6.6600	402,355	2						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	123,213			4,347	3						
4												4						
5												5						
	Working Capital																	
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	3,682,441	DEMAND	VARIES	279,228	6						
7	LETTER OF CREDIT FEE		X									7						
8												8						
9	TOTAL Facility Related				\$39,218.00		\$ 7,002,161	\$ 9,813,327			\$ 685,930	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	\$ 9,813,327			\$ 685,930	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 2007 report.	\$	83,800	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.)	\$	85,956	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,156	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	87,000	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.	\$	89,156	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	75,347	8
	2004	77,987	9
	2005	81,438	10
	2006	82,847	11
	2007	85,956	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>85,955.98</u>	\$ <u>85,955.98</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>85,955.98</u>	\$ <u>85,955.98</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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:

	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:

01/01/2008 Ending: 12/31/2008

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	\$	\$ 2,038,692	4
5		1997		10,762	391	27.5	391		4,483	5
6		1998		95,000	3,455	27.5	3,455		37,859	6
7										7
8										8
	Improvement Type**									
9	RELATED PARTY - MCKINLEY AVE, LLC									
10	OUTDOOR SIGNS	1997		13,284	483	27.5	483		5,534	10
11	REPLACE, REPAIR AND SEAL PAVEMENT	1998		6,754	399	15	450	51	4,725	11
12	REPLACE BLACK VALLEYS	1999		5,875	214	27.5	214		2,023	12
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS	1999		154,975	5,635	27.5	5,635		53,299	13
14	SPRINKLER SYSTEM	1999		4,744	173	27.5	173		1,635	14
15	COURTYARD IMPROVEMENTS	2000		5,975	353	15	398	45	3,781	15
16	RESIDENT ROOMS/BATHROOMS - PAINTING	2000		13,710	499	27.5	499		4,215	16
17	FIRE ALARM CONTROL PANEL	2000		6,703	244	27.5	244		2,063	17
18	REMODELING - ARCHITECT FEE	2000		1,493	88	15	100	12	850	18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATION	2001		7,382	268	27.5	268		1,999	19
20	REPLACED 2 YORK ROOFTOP HVAC UNITS	2003		11,340	412	27.5	412		2,249	20
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS	2003		19,732	718	27.5	718		3,919	21
22	STENCIL & COAT LANDING DOCK & WALKWAY	2003		4,397	160	27.5	160		873	22
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING	2003		2,000	73	27.5	73		399	23
24	PREPARE & RESURFACE NORTH PARKING LOT	2003		5,120	186	27.5	186		1,012	24
25	DRAPES, CURTAINS, BORDERS - SOUTH CORRIDOR	2004		21,455	1,915	7	3,065	1,150	13,793	25
26	PREP, PAINT, HANG WALLCOVERINGS & BORDERS-PATIENT &	2004		58,800	5,248	7	8,400	3,152	37,800	26
27	DRAPES, CURTAINS, BORDERS & SIGNS - LOBBY, BEAUTY SHOP	2004		14,052	1,254	7	2,007	753	9,032	27
28	BOARD FOR BEHIND THE HANDRAILS-FRONT LOBBY	2004		1,585	58	27.5	1,585	1,527	1,795	28
29	LIGHTING FIXTURES AROUND THE OUTSIDE OF THE BLDG	2004		3,335	121	27.5	3,335	3,214	3,774	29
30	DRAPES, VALANCE, RODS & HANDRAILS - PATIENT RMS	2004		12,350	1,102	7	1,764	662	7,938	30
31	OAK UNFINISHED CABINETS AND BAY WINDOW TREATMENT	2004		1,578	141	7	225	84	1,013	31
32	PREP & PAINT 26 BATHROOMS AFTER WALLPAPER REMOVAL	2004		3,800	339	7	543	204	2,443	32
33	REMOVE & DISPOSE ROOF BEHIND AIR CONDITIONER	2004		3,000	268	7	429	161	1,930	33
34	LAMINATED COUNTERTOP & SOLID SURFACE COUNTERS	2004		8,300	741	7	1,186	445	5,337	34
35	FURNITURE STORAGE WHILE REMODELING	2004		5,429	485	7	776	291	3,492	35
36	WIDEN TURNING RADIUS; PAVE PARKING LOT AND									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:

01/01/2008 Ending: 12/31/2008

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	\$ 1,049	15	\$ 1,010	\$ (39)	\$ 4,545	37
38	INSTALL VINYL SHEET FLOORING - CARPET HALLS	2004	82,244	7,370	7	11,749	4,379	52,728	38
39	PAINT AND PATCH 30 PATIENT ROOMS	2005	8,000	1,125	7	1,143	18	4,000	39
40	TWO ROOF TOP UNITS	2005	11,720	426	27.5	426		1,349	40
41	REPLACEMENT WINDOWS	2006	958	35	27.5	35		89	41
42	2 NEW ROOFTOP UNITS	2006	12,994	473	27.5	473		1,084	42
43	2 ASSISTANT SHOWER ROOMS	2006	8,880	323	27.5	323		686	43
44	TILES - NORTH NURSE'S STATION	2007	4,079	148	27.5	148		296	44
45	FLOOR MATERIALS FOR SOUTH NURSE'S STATION	2007	8,241	300	27.5	300		600	45
46	FIRE ALARM PANEL	2007	2,981	108	27.5	108		207	46
47	REMODEL EAST NURSES STATION	2007	6,925	252	27.5	252		483	47
48	INSTALL 4 THRESHOLDS FOR SOUTH CRDR-NURSES STA	2007	1,119	41	27.5	41		75	48
49	ROOF REPAIR	2007	6,200	225	27.5	225		357	49
50	CUBICLE CURTAINS	2007	10,513	701	27.5	701		1,110	50
51	85 GALLON WATER HEATER AND COOLER DOOR	2007	10,769	392	27.5	392		620	51
52	CARPET FOR ADMINISTRATIVE OFFICE	2007	1,060	106	10	106		141	52
53	SEALING AND ASPHALT - ENTIRE PARKING LOT	2007	19,930	1,993	10	1,993		2,657	53
54	ROOFING & GUTTERS	2007	3,580	130	27.5	130		130	54
55	PREP. & PAINT - 55 ROOMS, HALLWAYS, KITCHEN CEILIN	2008	15,319	1,277	10	1,277		1,277	55
56	INSTALL POWER EXHAUST FAN IN EXISTING DUCTWOR	2008	3,925	95	27.5	95		95	56
57	PAINT - DINING ROOM, BATHROOMS, & 57 PATIENT RMS	2008	2,445	82	10	82		82	57
58	REFLASH 2 AC UNITS IN EXISTING SHINGLE ROOF	2008	3,899	24	27.5	24		24	58
59									59
60									60
61			ADJ. TO SL	16,109			(16,109)		61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,432,143	\$ 228,690		\$ 228,690	\$	\$ 2,330,592	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	\$ 660,055	\$ 41,386	\$ 59,705	\$ 18,319	3-10 YRS	\$	71
72	Current Year Purchases	48,915	29,349	2,446	(26,903)	3-10 YRS		72
73	Fully Depreciated Assets	48,551				3-10 YRS		73
74	RELATED PARTY		4,054	4,054				74
75	TOTALS	\$ 757,521	\$ 74,789	\$ 66,205	\$ (8,584)		\$	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)	\$ 6,189,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 303,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,895	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,584)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,330,592	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: \$ **35,423** 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.	/2009	\$ _____
13.	/2010	\$ _____
14.	/2011	\$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 225,449	\$		\$ 225,449	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,475			88,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			250,350			250,350	4
5	Physician Care	39-3	visits							5
6	Dental Care	39-3	visits			2,716			2,716	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				261,168		261,168	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	RENTALS, LAB, I.V. THERAPY Other (specify): <u>X-RAY</u>	39-2					69,721		69,721	13
14	TOTAL			\$		\$ 566,990	\$ 330,889		\$ 897,879	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 203,524	\$ 409,917	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>826,904</u>)	1,814,975	1,814,975	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,618	95,461	6
7	Other Prepaid Expenses	4,311	4,311	7
8	Accounts Receivable (owners or related parties)	12,157	12,157	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		996,244	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,067,585	\$ 3,333,065	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,733,280	3,207,733	11
12	Long-Term Investments	1,351	1,351	12
13	Land		841,622	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		634,638	15
16	Equipment, at Historical Cost	757,521	757,521	16
17	Accumulated Depreciation (book methods)	(691,431)	(3,048,160)	17
18	Deferred Charges		130,863	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)	\$ 3,800,721	\$ 7,308,850	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,868,306	\$ 10,641,915	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,098,670	\$ 1,099,199	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	148,094	148,094	28
29	Short-Term Notes Payable	39,414	39,414	29
30	Accrued Salaries Payable	102,126	102,126	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,965	24,965	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,000	32
33	Accrued Interest Payable	153,855	35,479	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO LESSOR/PRIOR OWNER</u>	235,906	235,906	36
37	<u>MANAGEMENT FEES</u>	252,710	252,710	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,055,740	\$ 2,024,893	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,682,441	1,640,009	39
40	Mortgage Payable		6,007,673	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)	\$ 3,682,441	\$ 7,647,682	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,738,181	\$ 9,672,575	46
47	TOTAL EQUITY(page 18, line 24)	\$ 130,125	\$ 969,340	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,868,306	\$ 10,641,915	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 986,775	1
2	Restatements (describe):		2
3	UNCOLLECTIBLE NOTES - WRITTEN OFF	(162,784)	3
4	ROUNDING ADJ.	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 823,990	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(693,865)	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)	\$ (693,865)	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)	\$ 130,125	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	\$ 8,620,707	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,620,707	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	1,176	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)	\$ 1,176	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	39,447	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,447	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VINDING COMMISSIONS	1,846	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,846	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,663,176	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,358,130	31
32	Health Care	2,602,296	32
33	General Administration	3,362,028	33
	B. Capital Expense		
34	Ownership	1,054,358	34
	C. Ancillary Expense		
35	Special Cost Centers	897,879	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,357,041	40
41	Income before Income Taxes (line 30 minus line 40)**	(693,865)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (693,865)	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:

01/01/2008

Ending:

12/31/2008

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	2,385	2,596	\$ 92,766	\$ 35.73	1
2	Assistant Director of Nursing	1,948	2,587	60,698	23.46	2
3	Registered Nurses	5,873	6,201	130,330	21.02	3
4	Licensed Practical Nurses	37,728	40,680	900,904	22.15	4
5	CNAs & Orderlies	66,160	70,486	744,011	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,598	4,377	51,738	11.82	8
9	Activity Director	3,796	4,445	78,477	17.66	9
10	Activity Assistants	4,991	5,675	53,373	9.40	10
11	Social Service Workers	3,256	3,452	40,841	11.83	11
12	Dietician					12
13	Food Service Supervisor	3,707	4,196	56,106	13.37	13
14	Head Cook	9,194	10,190	95,208	9.34	14
15	Cook Helpers/Assistants	10,222	10,545	82,491	7.82	15
16	Dishwashers					16
17	Maintenance Workers	5,312	6,134	105,561	17.21	17
18	Housekeepers	16,443	17,930	187,815	10.47	18
19	Laundry	17,281	18,189	151,397	8.32	19
20	Administrator	1,735	1,944	74,038	38.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,316	11,166	194,337	17.40	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	6,593	7,149	121,235	16.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	210,538	227,942	\$ 3,221,326 *	\$ 14.13	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	194	\$ 10,751	1-3	35
36	Medical Director	96	30,000	9-3	36
37	Medical Records Consultant	18	2,210	10-3	37
38	Nurse Consultant	441	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	54	3,266	11-3	44
45	Social Service Consultant	54	3,266	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	953	\$ 137,210		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-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								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	06/2005	\$ 4,805	3	\$ 800	\$ 1,600	\$ 1,600	\$ 800																	
2	PAINT/DECORATING	06/2006	2,063	3		344	688	688	343																
3																									
4																									
5																									
6																									
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20	TOTALS		\$ 6,868		\$ 800	\$ 1,944	\$ 2,288	\$ 1,488	\$ 343	\$	\$	\$													

Facility Name & ID Number MCKINLEY COURT

0042499

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. - \$8475
- (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. \$ 2,369 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. \$ 82,350
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